SOCIAL WORKERS IN PRIVATE PRACTICE IN THE WESTERN CAPE: ATTITUDES AND RESPONSES TOWARDS PERSONS LIVING WITH HIV-INFECTION AND AIDS

by

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This dissertation is submitted in partial fulfillment of the requirements for the degree of Master of Social Science in Clinical Social Work in the Faculty of Social Science and Humanities at the University of Cape Town.

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DECLARATION

All information in this paper has been originally compiled and composed by the writer and the format and all references have been acknowledged according to the **Publication Manual of the American Psychological Association (2nd Edition).**

The study conducted is an original study with no falsification of information or results.

Lutricia Elzette Maree

University of Cape Town

DEDICATED

TO

MY PARENTS

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ABSTRACT

The Acquired Immune Deficiency Syndrome (AIDS) has increasingly become a serious public health threat, reaching pandemic proportions. Against this background, the role of health care professionals are becoming progressively more important due to the multi-faceted impact of the disease on the lives of HIV-infected and AIDS-patients.

The psychosocial impact of the disease compels social workers to contribute their services. The skills of clinical social workers however distinguish them from their counterparts in generic settings in that it enables them to create a therapeutic milieu conducive to the successful treatment of the AIDS-patient. Social workers in private practice may however be regarded as being in an even better position to deal with AIDS-patients due to the autonomous nature of their work environment. Several studies have been done both locally and abroad, on the role that knowledge, attitudes and behaviour of health care professionals play with regard to the treatment of the AIDS-patient. No such studies have however focussed on social workers in private practice as a population. Although this population have sets of skills most appropriate for the treatment of these patients, the question however recurs as to whether they are adequately equipped regarding AIDS-education, and if they do perhaps share similar feelings of fear, stigma and attitudes

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of discrimination towards these patients as have surfaced in the studies mentioned above.

This study therefore has as its main objectives the following: To establish whether social workers in private practice feel adequately equipped to deal with issues of HIV, AIDS and human sexuality; and to determine the degree of correlation among attitudes to AIDS-patients, homosexuals, terminally ill patients and sexuality, and other variables such as experience, gender and knowledge on the subject of AIDS.

For this purpose a self-administered questionnaire consisting of forty-one close-ended questions is used. Questions tested the knowledge regarding HIV-infection and AIDS, the amount of exposure respondents have had in working with HIV/AIDS-patients, their attitudes regarding working with such patients, and their views on the adequacy of their training in this specific field.

Questionnaires were mailed to the entire population of social workers in private practice in the Western Cape, and a response rate of 62 % was achieved. A Pearson product-moment correlation matrix was constructed from individual scores in order to assess the degree of correlation among variables mentioned above. Two-sample chi-square tests were conducted to compare attitudes of males and females of the

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population. The study indicates no significant correlations among the attitudes to AIDS-patients, knowledge on the subject, attitudes to homosexuals, attitudes to sexuality and that to terminally ill patients. Furthermore, there is a positive correlation between the degree of exposure to and experience with AIDS-patients, and attitudes to AIDS-patients. No significant difference could be found between attitudes of males and females with respect to HIV/AIDS-patients.

The implications for social workers in private practice are evident: AIDS education is imperative, offered in combination with appropriate consultation to address issues such as countertransference. Lobbying is necessary for protection of the rights of these patients, in addition to becoming familiar with accountability-issues which concern both patient and third parties involved.

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CLINICAL
SOCIAL WORKER : The person in direct practice and/or private practice who assesses the interaction between an individual's biological, psychological, and social environment with a view to appropriate clinical intervention.

RESPONDENT : The person within the sample who is being studied.

PRIVATE PRACTICE : It provides an autonomous working environment in which the control of the nature, pace and outcome of the social services is possible.

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CHAPTER 1

1.1. A BRIEF OVERVIEW OF AIDS

Rapid medical advances have been amongst the cornerstones of human development in the 20th century. Even though these advances have not benefitted all humankind, much misery and suffering have been eradicated as a result. Over the years an attitude of rejection in society was gradually replaced by a more enlightened attitude as scientific research led to the development of cures of most of the great scourges of the past, e g smallpox, tuberculosis, leprosy, bubonic plague, syphilis and cancer. These sufferers became regarded as tragic heroes. Since the identification of AIDS in 1981, the syndrome also became a focal point for medical researchers, in their search for a vaccine. Those suffering from AIDS are however not seen as tragic heroes.

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With the growing momentum of the incidence of AIDS, its incurable nature, and the fact that the latest International AIDS Conference held in Berlin in June 1993 presented a gloomy picture regarding progress in the medical field in their search for more knowledge concerning the disease, as well as vaccines, every person is confronted with the reality of the AIDS-phenomenon.

At present the incidence of AIDS is of such a nature that the World Health Organization projects that at least 30 million people could be infected with the AIDS virus by the year 2000. Experts who differ think the number could reach 110 million. Although AIDS education has slowed the epidemic in developed countries, the disease continues to spread in underdeveloped countries. Of growing alarm is the fact that the infection rate among women is rising rapidly and will presumably pass the rate of men by the year 2000. This shift indicates that HIV-infection and AIDS can no longer only be regarded as an illness among homosexual and bisexual men and intravenous drug abusers as was believed in the past, but that it is becoming a largely heterosexual disease as well on a world scale, with vast implications for the wider spectrum of society in all its facets (Gorman, 1992).

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According to Walsh (1992), speculations amongst scientists are at present that the discovery of different types of HIV may give an explanation for the phenomenon of the rapid spread of AIDS among men and women in Africa and parts of Asia, while the disease has not as yet portrayed a major heterosexual character in Europe and the USA. However, given the virus' ability to mutate, the disease may soon reach critical proportions as transmission via heterosexual activity in the First and Second World expands.

An important factor is the distinction which needs to be drawn between AIDS in the First World and AIDS in the Third World. It concerns the difference in its spreading, prevalence and reactions as well as strategies to address the combat of the disease. Social circumstances do differ between populations, i e homosexuals in the First World and populations in the Third World. This distinction is based on two epidemic patterns, i e the so-called First pattern characterized predominantly by the spread among homosexual and bisexual men and intravenous drug users, and the other epidemic being regarded as the so-called Third pattern, whereby the virus is spread via heterosexual conduct (Van Niekerk, 1991).

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According to Van Niekerk (1991) the so-called Third pattern is becoming the predominant trend in South Africa. He bases his statement on the latest figures which indicate that the virus is spreading rapidly among Blacks. The implication of this trend, as reflected in the most recent statistics on HIV-infection and AIDS in South Africa, is that a larger part of the population is at risk. The reader is referred to chapter 2 and Appendix II for the most recent global and local statistics on HIV-infection and AIDS.

The AIDS-epidemic is undoubtedly not only about a virus. The virus involves people and society in all its facets. Consequently, where inequalities and discrimination remain prevalent, the AIDS pandemic continues spreading at an even faster rate.

1.2. RATIONALE FOR THE STUDY

Given the fact that the AIDS-pandemic is reaching crisis-proportions without any medical cure in sight, the role and responsibilities of health care professionals are becoming increasingly important due to the political, economic, social, physical and psychological impact of the disease on both the HIV- and AIDS-patient. The psychosocial impact thereof compels social workers to become involved. The specialised skills of clinical social workers however distinguish them from their counterparts in generic settings who chiefly render generic assistance. Clinical social workers' training and focus creates a therapeutic milieu conducive to the assessment and management of the AIDS-patient in a context of dynamic factors such as diagnosis of psycho-social concerns and management through in-depth interpersonal skills. In addition, the autonomous nature of their work environment assists social workers who are in private practice to deal with AIDS-patients, especially in terms of long term commitment, confidentiality and follow-up. Several studies have been

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done both locally and abroad, on the role that knowledge, attitudes and behaviour of health care professionals play with regard to the treatment of AIDS-patients, and the outcome of such treatment (McManus & Morton, 1986; Pitts et al, 1990; Larsen et al, 1991; Dow & Knox, 1991; Peterson, 1991; Schlebusch et al, 1991; Eagle & Bedford, 1992; Coyle & Soodin, 1992). No such studies have however focussed on social workers in private practice as a given population. For the purposes of this dissertation direct service practice, clinical social work and private practice will be used interchangeably. Services rendered by generic social workers may involve the community at large, the family or the individual. It may for example involve divorce mediation. The clinical social worker renders services which stretches from counselling and therapy to psychotherapy with individuals, and intensive therapeutic work with couples and families. Its purpose is to enable the person(s) in treatment to live a fully integrated life within society.

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1.3. RESEARCH OBJECTIVES

With the major assumption of this research being that social workers in private practice have a role to play within the HIV-and AIDS-arena, several questions emerge which can be phrased as hypotheses and serve as the research objectives:

a) Determine whether social workers in private practice who have a clinical emphasis, feel adequately equipped to deal with the issues of HIV, AIDS, and human sexuality;

b) Assess whether there is any correlation between homophobia, i e the irrational fear of homosexuals, and attitudes towards AIDS-patients;

c) Establish the extent to which treatment of the AIDS-patient is influenced by possible discrimination, feelings of bias as well as a lack of specialised knowledge on AIDS;

d) Determine whether there is any correlation between attitudes to terminally ill patients in general and to AIDS-patients in particular so that the degree to which the former attributing to the latter can be gauged;

e) Ascertain whether there is any correlation between exposure to and experience with AIDS-patients and attitudes to AIDS-patients;

f) Establish whether there is any correlation between the attitudes of males and that of females with relation to AIDS-patients.

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1.4. CHAPTER LAY-OUT

The study is organised as follows:

Chapter 1 presents the reader with a brief look at the phenomenon of the AIDS-pandemic as far as its main facets are concerned. Thereafter, the importance of performing a study of this nature is discussed. The research objectives are then outlined in the form of hypotheses, followed by a chapter lay-out, and the overall strategy used, including some of the weaknesses of the study.

Chapter 2 reviews relevant literature on HIV-infection and AIDS. It includes a look at the medical and scientific background to the disease, its modes of transmission, the most common diseases associated with AIDS, the treatment of HIV and AIDS, and global as well as local statistics on the disease. Special reference is made to its incidence in the Western Cape.

Chapter 3 distinguishes between generic and clinical social work. It also examines the functions that the social worker in private practice serve within society. The chapter highlights the role of the clinical social worker in private practice within the AIDS-arena.

Chapter 4 sets out the research methodology. It also

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presents the findings of the research and discusses it.

Chapter 5 presents the implications of the research results for social work practice. It also includes relevant recommendations.

Chapter 6 concludes and summarizes the research.

1.5. STRATEGY EMPLOYED IN THE RESEARCH STUDY

A self-administered questionnaire is used to collect the data. This questionnaire consists of 41 close-ended questions that range from the testing of the knowledge of the respondents on HIV-infection and AIDS as an illness, the amount of experience that the respondents have in working with AIDS-patients, their attitudes regarding working with these patients, testing for homophobia, attitudes to terminally ill patients, to the establishment of their views on being adequately equipped to work within the AIDS-arena.

The total population of social workers in private practice within the Western Cape is used as sample to perform the research.

Some weaknesses of the study are brought to the reader's attention at this stage:

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a) The sample findings are not representative of the entire clinical social work community in South Africa nor of the social work community in general. It would therefore be wrong to extrapolate conclusions of this study to these populations.

b) There is no attempt to undertake a detailed analysis of the variances in responses - i e to what extent differences in age or university training can explain variances in attitudes and knowledge.

c) By using parametric procedures it is implicitly assumed that the relevant random variables are normally distributed or that it cannot be shown that it is not the case.

d) Direct service practice, clinical social work and private practice are used interchangeably. This could be perceived as a major limitation in that not all private practitioners are clinically trained.

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1.6. SUMMARY

This chapter introduced the reader to the rationale for and objectives of this study against the background of the nature of and extent to which the AIDS-virus is impacting on the lives of people on a worldwide scale. Projections about the momentum of its spread given its incurable nature, explain its importance as phenomenon to be researched in all its facets, with a view to improving the quality of services rendered to humankind who may be affected by its horrific impact.

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CHAPTER 2

HIV-INFECTION AND AIDS, IN GENERAL, WITH SPECIAL REFERENCE TO CAPE TOWN.

In this section the clinical/medical and scientific background to AIDS as well as most recent findings concerning the disease will be discussed. The most recent statistics on AIDS on a global level, in Africa, within South Africa and especially within the Western Cape will also be included. AIDS resource centers in South Africa, with special reference to the Western Cape, will also be highlighted.

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2.1. CLINICAL AND SCIENTIFIC BACKGROUND TO AIDS.

In 1981 the Centers for Disease Control in Atlanta, USA, became the first source in medical history to describe the phenomenon of AIDS. The Centers described AIDS as an illness associated with a defect in cell-mediated immunity, such as Kaposi's Sarcoma (KS), Pneumocystis Carinii Pneumonia (PCP), or any other serious infectious disease. Usually there is no known explanation for the immunological deficiency, e g congenital immuno-deficiency (Huber et al, 1992).

Kelly et al (1989, p 2) define AIDS as follows:

> "AIDS is defined as a reliably diagnosed opportunistic disease or infection that is predictive of cellular immune deficiency and occurs in a person with no known preexisting illnesses or therapies that would produce immunosuppression."

In attempting to understand AIDS in all its facets the human immunodeficiency virus (HIV) was recognised as the virus responsible for the unusual serum antibodies recognised in most AIDS-patients. The virus manifests differently, as will be discussed in greater detail later in this chapter, and has a long incubation period. Of importance is the trend that 75% to 100% of asymptomatic carriers of the virus develop symptoms of HIV and eventually become terminally ill with full-blown AIDS, while 25% remain asymptomatic carriers of the virus (Kelly, 1989; Almond, 1990; Cohen, 1990). The essential difference between HIV and AIDS is therefore that AIDS is a terminal illness whereas HIV is not and may as such never develop into the terminal stage of full-blown AIDS. This phenomenon has implications for social work intervention, and will be discussed in full detail in chapter 3.

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Work against the AIDS-pandemic during the 1990s however indicates that changes have occurred on two levels. In the first instance 'the evolvement of the epidemic took

place in societal and geographical terms (as will be discussed more extensively later in this chapter). Secondly, an increase in clinical knowledge concerning HIV and AIDS as a result of new insights as well as changes in the clinical aspects of the pandemic, followed. This has led to revisions of the original definition of AIDS, leading to the co-existence of four different case definitions of AIDS. These include the WHO/CDC (World Health Organization/Centers for Disease Control) definition which is based on indicator diseases, the Bangui definition, the Caracas (Caribbean) definition, and a laboratory-based CD4 definition (De Vita et al, 1992).

2.2. HIV AND ITS RELATION TO AIDS

The development of AIDS relates to compromised immune system functioning, which is why knowledge concerning the origin of AIDS-related immune deficiency is important in introducing the medical characteristics of the disease. After much speculation and medical research in Europe and the USA, unusual serum antibodies were recognised in most AIDS-patients. The Human Immunodeficiency Virus (HIV) then became the term of the virus held responsible for the antibodies (Kelly et al, 1989).

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2.2.1. THE BASIC STRUCTURE OF HIV

There are seemingly three characteristics inherent in the basic structure of HIV (Almond, 1990). The virus consists of an outer membrane, nucleic acid in the middle and an inner core. Not being a virus product and consequently unable to be repaired by the virus, the outer membrane carries the physical characteristics of the virus. The nature of the outer membrane determines how the virus will be transmitted and what will inactivate it. Since the lipid membrane of the virus is easily disrupted by environmental changes, disruption results in inactivation, resulting in poor survival of the virus outside the human body. The middle of the virus contains its genetic code as well as the proteins. These proteins are carriers of biological properties of which three need further discussion. Firstly, the property of latency implies that once a person's cell has become infected by the virus, it remains a lifelong infection. In the second instance, infectiousness increases due to the fact that it is a productive infection. Thirdly, the HIV-virus attacks specific cells in the body which are known as the T-cells as well as macrophages of the immune system. The virus can therefore cause two types of disease. It can cause progressive immune deficiency. This can be identified in AIDS-Related Complex (ARC) and AIDS itself. The immune deficiency results from the loss of T-cells, resulting in

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the infected person becoming prone to infections and tumours, damage to the nervous system, resulting in dementia or the loss of motor function (Almond, 1990).

2.2.2. NATURAL PROGRESS OF THE ILLNESS

The health course of people who become infected with the HIV-virus cannot be predicted due to the fact that the clinical manifestations of the virus itself vary across individuals, and is exacerbated by the long incubation period of the virus.

The latent period, i e from the period of exposure to the virus to the onset of clinical disease, range from one to ten or even fourteen years (Kelly, 1989; Lachman, 1991). When someone thus contracts the virus, the person remains asymptomatic and HIV negative for a period ranging from between three weeks to six months before sero-conversion follows. At this stage the virus appears to be in the blood, resulting in the person being diagnosed HIV positive but asymptomatic. After a period of between one year to fourteen years, about 75% to 100% of those who are asymptomatic become symptomatic due to the chronic nature of the infection. Signs such as weight loss, swollen glands, fever, diarrhoea, night sweats and weakness become evident, indicative of a progression towards the terminal phase of the illness. Approximately 25% remain asymptomatic, yet carriers and

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potential transmitters of the virus (Almond, 1990; Cohen, 1990). According to Kelly (1989) the person enters the terminal stage of the illness when the HIV virus has undermined the bodily immune system's capacity to resist infections and illness, leading to dangerous infections, cancer, brain tumours, etc. which eventually results in the death of the person.

2.3. TRANSMISSION OF THE HIV-VIRUS

Transmission of the HIV-virus takes place via three means. Firstly, via sexual activities, in which instance the HIV-infected person's blood, semen, and/or body fluids enter the partner's bloodstream. Secondly, the virus can be transmitted from an infected mother to her child. Thirdly, the transmission of the virus takes place via the transmission of blood or the use of needles for the injection of drugs that were used by HIV-infected persons as well (Kelly et al, 1989; Almond, 1990).

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Transmission of the virus through sexual activities is but one means of transmission. It includes transmission from male to male, male to female, female to male and female to female. Between 66% and 70% of AIDS cases have been reported to have occurred in homosexual and bisexual men in the USA and European countries like Sweden, the United Kingdom, Norway, Denmark, the Netherlands, and the former Federal Republic of Germany. Regarding male-to-

female transmission and female-to-male transmission the trend appears to differ. While 3% of men and 34% of women in the USA are seemingly AIDS-sufferers due to heterosexual contact, in Africa and Latin America the ratio of infected males to females is about 1:1 indicating that transmission via heterosexual means is predominant. Transmission of HIV by prostitutes in the USA, Europe and Africa however needs to be researched further, after which the findings may influence current statistics on female-to-male transmission. An insignificant number of cases of infection among lesbian women has been documented, making transmission from female to female very rare (DeVita Jr. et al, 1992; Cohen et al, 1990).

In the instance where transmission of the virus takes place from the infected mother to the child, it can occur before or after birth. The unborn child can become infected with the virus via the mother's placenta. In this case the mother's stage of infection as well as her degree of immunodeficiency appear to be indicative of the likelihood of transmission. Transmission of the virus to the baby during delivery, due to exposure to blood in case of vaginal delivery, remains to be uncertain. However, transmission during Cesarean section cannot be ruled out because of reported cases of HIV-infected babies born by Cesarean section. There appears to be

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evidence that transmission via breast feeding is possible, even though its risk has not yet been defined. A few cases which suggest postnatal transmission via breast feeding had however been reported in the USA (DeVita Jr. et al, 1992; Almond, 1990; Cohen, 1990).

The transmission of the HIV-virus via the transmission of blood is prevalent among persons with hemophilia, among the recipients of blood, as well as among intravenous drug users who have used contaminated needles and syringes. A number of health care workers have also become infected in reported cases in the USA after exposure to HIV-infected blood. While the lack of screening for HIV-infection among blood donors seems to result in transmission in several developing countries, the donation of blood shortly before HIV antibody testing was instituted by blood banks, can be held accountable for the transfusion of HIV-infected blood in developed countries. It appears that 9% of children and 2% of adults have become infected with the virus via blood transfusion. Sexual activities as well as the sharing of needles and syringes already used by drug users, can both lead to HIV-infection among intravenous drug users. It is estimated that while transmission of the virus is declining among homosexual men, transmission in intravenous drug users are on the increase. In the USA 19% heterosexual men and 7% homosexual and bisexual men who are AIDS-sufferers reported a history of intravenous

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drug usage. 59% of infected children's mothers were intravenous drug users or had sexual partners who were intravenous drug users (Cohen et al, 1990; DeVita Jr. et al, 1992).

Risk factors involved in HIV transmission are linked not to sex or sexuality patterns only, but to the number of partners as well as their risk of infection. Culture plays a definite role as determinant of the rate of the spread of the virus as different populations may display extremes of sexual behaviour. In the one population, for example, most people have only one sexual contact, resulting in the slow spread, and a small proportion of the population becoming infected with the virus. In the other population, however, where multiple sexual contacts prevail, the virus will spread much more rapidly, increasing the risk of those with quiet life-styles as well (Almond, 1990). In addition to this fact, DeVita (1992) also highlights the role of other risk factors such as poor housing facilities due to poverty, which form the ideal breeding ground for diseases such as tuberculosis, especially given the combination of nutritional factors and damp conditions which this population is exposed to.

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2.4. MOST COMMON DISEASES ASSOCIATED WITH AIDS

The diseases which are most commonly associated with AIDS include Kaposi's Sarcoma (KS), dermatological conditions, neurological disease, syphilis in HIV patients, renal disease, cardiac complications, and certain tumours. Occurring mostly among homosexuals who have contracted AIDS, Kaposi's Sarcoma usually occurs together with other opportunistic infections in order for the patient to die. Dermatological conditions include a high incidence of drug rashes due to drug reactions in HIV-infected people (e g hypersensitivity to standard chemotherapy), common skin conditions such as cat-scratch disease and other dermatoses such as herpes simplex. Neurological disease is common among AIDS-sufferers, with 90% of autopsied AIDS-patients indicating abnormalities of the central nervous system. Renal disease present with features such as enlarged kidneys. While treatment of AIDS-patients with certain drugs may account for cardiac abnormalities, cardiac factors in young patients with AIDS are becoming a frequent phenomenon, with no certainty about the cause of the abnormalities (Lachman,1991).

2.5. MEDICAL TREATMENT OF HIV AND AIDS

Into the nineties, a decade after AIDS first became known and researched by the medical profession, neither a vaccine, nor a cure has been found, to effectively treat

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the disease. HIV is able to mutate its structure, and therefore elude its detection, as well as the specific drugs and vaccines used in treatment. Scientists still raise questions about how HIV destroys the human immune system. Especially after cases totalling up to thirty, have been under discussion in July 1992, at a fairly recent AIDS-Conference held in Amsterdam, of patients displaying symptoms of full-blown AIDS in the absence of having been infected with the HIV-virus. This revelation immediately raised new questions among scientists, ranging from whether a new AIDS virus is emerging, to whether these so-called strange cases are the result of the mutant forms of the HIV-virus that changed too rapidly to be identified via blood tests. Another theory developed by Dr. Gupta of the USA, expressed the possibility of these patients having problems with their immune systems that mimics AIDS. Although scientists hold onto the theory that the virus needs to provoke immune-system cells to destroy themselves, implying that an assistant assailant namely a so-called co-factor is necessary, their search for co-factors have remained inconclusive (Gorman, 1992).

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2.6. STATISTICS ON HIV AND AIDS

2.6.1. A GLOBAL PERSPECTIVE

In this section trends within certain countries will be discussed in detail, in accordance with most recent surveys. The reader is however referred to Appendix I for the most recent statistics released by the World Health Organization for an overview of the current situation in each other country not fully discussed here.

Current statistics worldwide indicate that the spreading of AIDS in India is gaining the proportions of where Africa was a decade ago. India has 8,081 recorded virus carriers and 194 AIDS-carriers. However, unofficial estimates are that 400,000 of the population is infected and 12,000 has AIDS (Haworth, 1992).

Walsch (1992) states that a current study in Thailand has indicated that HIV has shown predilections for different human host cells in different parts of the world. Molecular biologists at the United States Centers for Disease Control found two different epidemics which were caused by different strains of HIV in northern Thailand. These epidemics started only four years ago, with one prevalent mostly amongst intravenous drug abusers while the other epidemic started in female prostitutes. The

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researchers discovered that the infection prevalent amongst the prostitutes bore strong resemblance on the types found in Africa. Haworth (1992) claims that Thailand is speculated to have between 200,000 and half a million carriers out of a population of 56.3 million. The World Health Organization estimates that the Philippine has 14,000 HIV-carriers. In Bangkok the use of prophylactics in households has increased from 10% during 1989 to 90% in 1992, indicating that Bangkok may well be a worldwide leader in the fight against the spread of AIDS.

In Brazil heterosexual transmission of the virus has more than tripled since 1989 (Haworth, 1992).

2.6.2. AFRICA

While this section will briefly deal with most recent surveys conducted in Zambia, Zimbabwe and other African countries regarding the spread of the HIV-virus and AIDS, the reader is referred to Appendix II for an update on AIDS-cases in all the respective African countries.

In African countries like Zambia, a recent study indicated that 24.5% of women who paid visits to Lusaka's pre-natal clinics were HIV-infected. A maternity hospital in Nairobi's statistics have brought to light that 10% of the 150 babies born daily are carriers of the

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HIV-virus. UNICEF has indicated that at the present rate the spread of the virus will leave 5.5 million children in East and Central Africa orphaned within the next decade (Branegan in Haworth, 1992). A study performed in Nairobi has shown that tuberculosis (TB) is an important association of HIV infection because in 40% of the new cases of active TB these patients were HIV positive, the highest recorded seroprevalence among TB patients yet in Nairobi (Gilks et al, 1990).

Reported AIDS cases in Uganda since the discovery of the disease were 30,190 at the end of 1991 (WHO Global AIDS Statistics, 1992). In a new development in AIDS control in Uganda a voluntary and confidential public HIV testing and counselling service was opened in 1990. Although little published information exists regarding the feasibility and impact of such services on African populations, it is clear that these services need to be regarded as only an additional approach for the reduction of HIV transmission in Africa (Muller et al, 1992).

The number of reported AIDS cases in Zimbabwe are indicating an increase in the prevalence of AIDS in the country. While 1,625 AIDS cases were reported in the fourth quarter of 1991, only 724 cases were reported in the first quarter of 1991. The number of reported AIDS cases in Zimbabwe were 12,514 as at 31 March 1992 (Van Coeverden de Groot et al, 1992).

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A study performed in Kinshasa, Zaire among an urban African workforce has indicated a 3.3% HIV infection rate among male employees and 3.8% among their spouses. The HIV seroprevalence rate was found to be higher among female employees (7.7%). Women employees were younger and only a small proportion of them were married, while wives of male employees had as the most important risk factor a husband who is HIV positive. Heterosexual transmission patterns emerging from the study highlighted extramarital and prostitute sex among married men followed by unprotected sex with their wives, and young single women's sexual patterns to be the main causes (Ryder, 1990).

HIV seroprevalence in the People's Republic of Angola was found to be lower in northern, north eastern and central-southern parts of the country (14.2%), in comparison with the prevalence rates in the northern and central areas. This phenomenon seems to be related to people displacements due to the war playing a definite role in the spread of the HIV virus (Santos-Ferreira et al, 1990).

If risk factors are considered with regard to the spread of HIV and AIDS in African countries with the highest prevalence (i e Zimbabwe, Ethiopia and Senegal - see Appendix II), it is suffice to add that the Third pattern

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of the disease is a reality in these countries. Heterosexual activities account for the spread of the disease in these regions. Kelly (1989) acknowledges this fact, adding that the majority of those who become infected with the HIV virus, do not have any history of homosexuality, drug use, or blood transfusions. Females are therefore at equal risk in becoming affected, as well as in giving birth to HIV-carriers. It is clear that heterosexual promiscuity stands accountable for the rapid spread of the virus, placing those who live quiet lifestyles at equal risk due to their own multiple heterosexual contacts.

2.6.3. THE SOUTH AFRICAN SCENARIO

The current reality regarding the spread of HIV and AIDS will be discussed in this section. The reader is however referred to Table I for an update on the annual number of cases reported in South Africa as on 27 October 1992, and to Table 2 for details on the transmission category by ethnic group and sex.

In South Africa the incidence of HIV infection and AIDS is reaching its most dangerous stage. There are three different stages in identifying the epidemic, the first having been the spreading of the AIDS virus in a so-called silent way, over a period of approximately ten years before the first signs of the virus became visible.

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The second stage, i e the symptomatic stage, was characterized by people falling ill and dying, from diseases like pneumonia as a direct result from AIDS. The third phase is described as where the consequences of AIDS and its horrific impact became felt widely, e g the inability of health and social services to deal with the vast number of AIDS-sufferers, and the suffering of families and communities as a result of the deaths (Caret, 1992).

The Department of National Health reported that 201 South Africans had developed full-blown AIDS within the last four months of 1992. These latest figures had totalled the number of AIDS-carriers in South Africa to 1,517 since 1982. The Department of National Health and Population Development however stated that in May 1992 200,000 South Africans had already been infected with the HIV-virus. This Department expects the number to rise by another 100,000 (Cape Times, 6th November 1992).

Another reality regarding the incidence of AIDS in South Africa is that South Africa is on the brink of facing the same deterioration in the spread of AIDS as in other African countries. Estimates are that on the average two HIV-positive women give birth at the Baragwanath Hospital in Johannesburg on a daily basis. Approximately half of these women were never tested, and are from areas surrounding Soweto and from Soweto itself. Other

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estimations have it that currently 30-40% of the babies born from HIV-positive women are infected and will develop full-blown AIDS (Cape Times, 10th November 1992).

The number of HIV-carriers identified in the Cape Province during the first eight months of 1992 have already exceeded that of the whole of 1991. More than 1,870 people within the Cape Province have now unofficially been diagnosed as AIDS-carriers. It is also emphasized that this reported number is only a small percentage of the actual number of AIDS-carriers within the community. Dr. Vurgarellis, Regional Director of National Health Services in the Cape, stated that 169 AIDS-carriers have been identified between July and August 1992. Projections are that if the momentum of the incidence of AIDS continues at this rate within the Cape, it will result in the identification of between 70 and 100 new AIDS-carriers per month, within the parameters of those people who are being tested (Die Burger, 5th October 1992).

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Update on AIDS in South Africa as on 27 October 1992

TABLE 1: Annual number of cases reported in South Africa

Year of diagnosis	Total cases	Deaths	Case-fatality rate (%)
1982	2	2	100
1983	4	3	75
1984	8	8	100
1985	8	8	100
1986	24	23	96
1987	40	33	83
1988	91	56	62
1989	175	97	55
1990	318	88	28
1991	436	105	24
1992	411	52	13
Total	1517	475	31

(Van Coeverden de Groot et al, Dec. 1992)

Table 1 exhibits an escalating trend in the number of AIDS-cases within South Africa. This is indicative of the fact that the virus is spreading more rapidly now despite the notion that there should be a greater awareness among the public about the existence of the disease, its implications given the fact of unprotected sex, and knowledge regarding safety precautions in their sex lives, in comparison with 1982. These statistics indicate that South Africa is becoming one of the countries in Africa with among the highest percentage rates in the transmission and spread of the virus.

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TABLE 2: Transmission category by ethnic group and sex within South Africa

		Homo/bi-sexual	Hetero-sexual	Haemo-philiac	Trans-fusion	IVDU	Paed-iatric	Total
Asian								
	M	4	1	0	0	0	0	5
	F	0	0	0	0	0	0	0
Black								
	M	3	374	3	4	1	138	523
	F	0	390	0	0	0	114	504
	U	0	12	0	0	0	4	16
Coloured								
	M	21	13	1	1	0	0	36
	F	0	12	0	1	0	0	13
White								
	M	370	14	13	12	1	0	410
	F	0	4	0	4	0	0	8
	U	0	1	0	1	0	0	2
Total								
	M	398	402	17	17	2	138	974
	F	0	406	0	5	0	114	525
	U	0	13	0	1	0	4	18
Grand Total		398	821	17	23	2	256	1517

(Van Coeverden de Groot et al, DEC. 1992)

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Table 2 indicates that there are six transmission categories into which the spread of the virus can be divided in South Africa. Regarding the sexual orientation of the person who transmits the virus, the table reflects a dominant heterosexual trend in the transmission of the HIV virus. It is also evident that this trend is found largely among Blacks, with White homosexual men being the ethnic group who are in the second most likely position to transmit the virus. The

heterosexual pattern is further emphasized in paediatrics reflecting the third highest score. It seems from this table as though multiple unprotected sexual contacts is currently a prevalent trend among the heterosexual Black population in South Africa.

2.6.4. The Western Cape

Within the Western Cape, the spread of HIV-infection and AIDS is on the increase, given figures about its spread elsewhere in the world. The latest statistics indicate that between January 1992 and October 1992 771 people have been tested and found HIV seropositive. In table 3 below monthly totals are shown for the year 1992.

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TABLE 3 New cases in the Western Cape for 1992

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Unknown risk	42	34	36	32	45	35	38	21	32	9
Hetero-sexual	24	33	25	43	29	31	44	45	60	41
Female Prosti-tution										
Bisexual										
Blood or Bloodpro-duct										
Male Homo-sexual	1	3			1		4	1	2	1
Paedia-tric	5	7	3	6	5	6	10	6	6	5
IV Drug Use										
Total	72	77	64	81	80	72	96	73	100	65
White Female		1							1	
White Male	3	1	1	1	1	1	2	2	4	1
Col. Female	6	4	7	7	4	9	11	9	15	6
Col. Male	10	7	7	6	9	7	11	9	8	4
Black Female	13	27	15	34	24	22	28	19	17	17
Black Male	17	21	24	21	20	24	26	16	26	18
Unknown	23	16	10	12	22	9	18	18	29	10
TOTAL	72	77	64	81	80	72	96	73	100	56

(ATICC, Passive Surveillance of HIV seropositive sera: October 1992).

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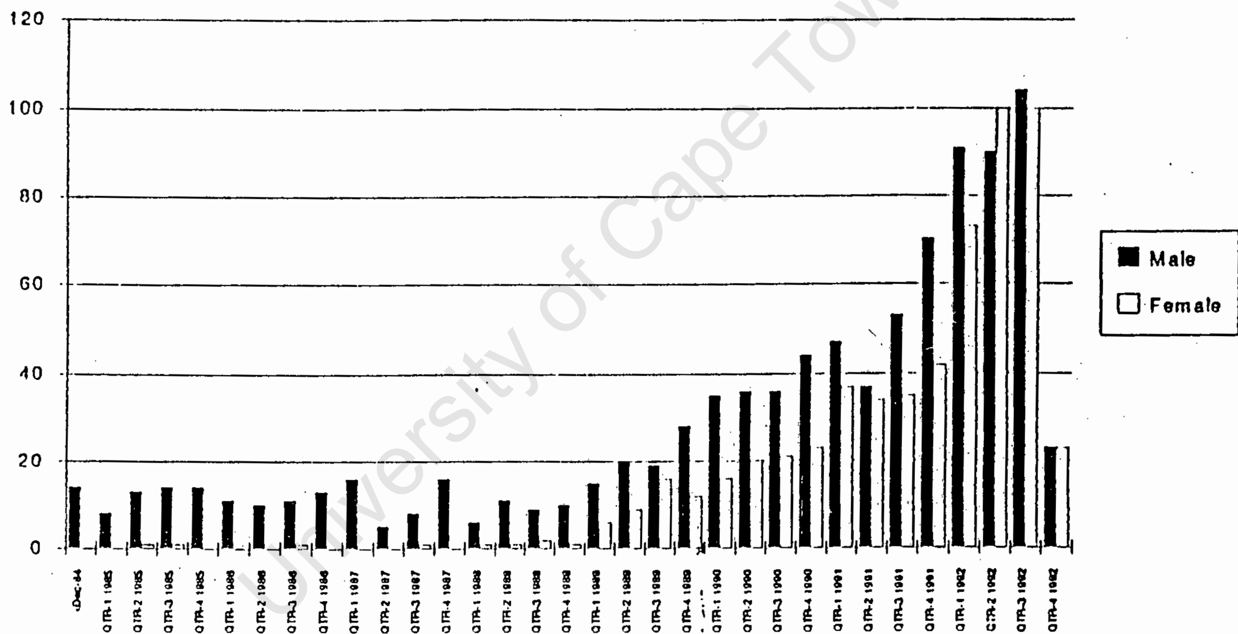
These recorded cases in table 3 resulted in 56 HIV-carriers in the Western Cape during October 1992 being identified, indicating heterosexual behaviour as an important means of transmission of the virus, amidst the reality that the black population outweighs all the other population groups in number.

Figure 1: Sex Ratio



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(ATICC, Passive surveillance of HIV seropositive sera: October: 1992)

This figure indicates an increase in the number of females infected in the Western Cape as has been indicated to be the reality on a larger scale in the whole of South Africa. It can therefore be expected that

more infants will become carriers of the virus, increasing the number of paediatrics as category of HIV carriers, as the heterosexual trend gains greater momentum in South Africa as in countries such as Zimbabwe.

TABLE 4 Risk factors: Its relation to transmission patterns.

Distribution by risk	1985/ 1989	1990	1991	1992	TOTAL
Unknown	224	159	262	324	969
Heterosexual	28	111	176	375	690
Female Prostitution	5				5
Bisexual	24	1	2		27
Blood or Blood Product	24	2			26
Male homo- sexual	125	25	33	13	196
Paediatric	3	8	39	59	109
I V Drug use	3	1			4
TOTAL	436	307	512	771	2026

(ATICC, Passive surveillance of HIV seropositive sera: October 1992)

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Table 4 reflects current and previous transmission patterns within the Western Cape. While male homosexuals held the greatest risk in terms of transmission of the virus between 1985 and 1989, and the risk among heterosexuals was very low in comparison, the table exhibits very clearly that although the transmission rate

among homosexual males has shown a steady increase between 1985 and 1992, the transmission rates among heterosexuals are currently far outnumbering them as risk group. The heterosexual population has become the leader in the transmission of the virus.

The reader is referred to Appendix III for relevant information regarding AIDS Resource centers within South Africa (The Cape Times, 6th May 1992).

2.7. SUMMARY

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In this chapter, HIV-infection and AIDS were explored in relation to its most important facets. In order to achieve this goal, the clinical and scientific background to AIDS as a disease was examined. This took place against the backdrop of a discussion of how HIV is related to AIDS given its chronicity. The basic characteristics of HIV were discussed, and linked in importance to the development and progression of the disease, from its asymptomatic stage through to the symptomatic stage years later, and the onset of the terminal phase of the disease when full-blown AIDS becomes the diagnosis for treatment-purposes, until death follows due to any related disease.

The transmission of the HIV-virus was discussed at length in relation to the different modes of transmission, the

groups at greatest risk of spreading the disease, and the risk factors involved in the actual transmission of the virus. The most common diseases associated with AIDS were also discussed, as well as the current situation regarding medical attempts to discover a vaccine or a cure to effectively treat people who are HIV-infected and those who are living with AIDS, as well as exploring potential reasons for the difficulty involved in finding a cure.

Furthermore, an overview was presented on statistics on the incidence of HIV and AIDS. It included an exploration of the current global situation, the trend in Africa, a separate look at the overall trend in South Africa, and finally an in-depth examination of the nature of the transmission trends within the Western Cape. This detailed look at both the ethnic and sex groups and its relation to transmission patterns clearly indicated that the disease is becoming more of a heterosexual one.

Given the fact that AIDS has become an issue of worldwide significance, its presently incurable nature, and the horrific impact of its spread on all sectors within society and on family life in particular in South Africa, the writer examines in the next chapter the ways in which the social worker can contribute towards the enhancement of a quality life for those infected with HIV and those who have AIDS, as well as with regard to the significant

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others who are also affected by the reality of the illness.

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CHAPTER 3

CLINICAL SOCIAL WORK, ITS RELATION TO PRIVATE PRACTICE, AND THE ROLE OF THE CLINICAL SOCIAL WORKER WITHIN THE AIDS-ARENA

3.1. GENERIC SOCIAL WORK IN PUBLIC AND PRIVATE AGENCIES VERSUS SOCIAL WORK IN PRIVATE PRACTICE.

This section deals with the important distinction which needs to be drawn between social work practiced in public agencies and social work practiced in private practice, due to its relevance for the purposes of this study. The historical development of social work as profession will be briefly discussed as well, in order to create an understanding of the nature of service-delivery today. Preconditions for running a private practice on a part-time basis will also be examined. The implications that private practice hold for the social work profession will be under scrutiny. In the final instance a brief look will be taken at fields of service in private practice.

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Social work as it originally became known, served the needs of the poor. Known as generic social work, the work involved an emphasis on the individual's environment and its manipulation by trained social workers employed by public agencies. Casework, groupwork and community work became methods whereby services were being rendered to the poor,

dispossessed, disabled and delinquent (Howe, 1980). The nature of the generic services being rendered today still include these methods of intervention. Casework serves an individual client's needs, e g finding a foster home for a neglected child, etc. Groupwork focuses on the needs within particular groups, e g equipping mothers of children with Down's Syndrome with the necessary coping skills in caring for their children, hereby also rendering a supportive function within a group context. Community work, with its emphasis on intervention on a community level, may involve the development of schools to teach specialized subjects which the community needs (Orten, 1987).

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With the advent of Freud and the development of the psychiatric thrust in social work, social workers employed by public agencies began to provide psychiatric services after the Second World War. As treatment modalities, these services focussed on psychic, somatic and interpersonal disorders of an individual, family or group, using psychological means such as the treatment relationship. More recently, clinical social work has expanded to incorporate the relationship between the individual and external social and political forces, that is - more systematic in its approach. Clinical social work differs from psychoanalytic therapy in that it

embraces a social enterprise while the latter usually focuses on the psychic structure of the individual. With the decline in cases of war-time neuroses which were being treated through psyhoanalysis, more disturbed symptomatologies, now known as character disorders, (e g the borderline personality) emerged. It demanded a therapeutic model that led to the establishment of clinical social work which recognises the unconscious as the decisive quality of the feelings and psychic world of the individual. In treatment, the therapeutic milieu and its function as container of the infantile ego is therefore considered to be the most important instrument of care (Courtney, 1992; Federn, 1992).

A task group attempting to define clinical social work, concluded that ... "clinical social work involves a wide range of psychosocial services to individuals, families, and small groups in relation to a variety of human problems of living. Such practice may be carried out under both private and public auspices. It is concerned with the assessment of interaction between the individual's biological, psychological, and social experience, which provides a guide for clinical intervention. A distinguishing feature is the clinician's concern with the social context within which individual or family problems occur and are altered" (From the foreword of Rosenblatt et al, 1983).

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Between the First and Second World War psychiatric social workers attempted to develop private practice, representing a desire to focus more on the individual's personality and using the relationship between worker and client in treatment, outside the boundaries of a governmental agency or duly incorporated voluntary agency. The private practice of social work therefore developed out of the practice of psychotherapy by social workers who had the desire to independently practice psychotherapy. Economic pressures and a recession during the 1940's limited the scope of private practice. The attempts of these social workers to gain access to middle-class clientele and achieve professional autonomy however remained because consequently, with the rise of the middle class between the late 1940's and 1950's, the efforts of private practitioners led to the certification and licensing of workers (Courtney, 1992).

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Social workers in private practice today are therefore, in comparison with their counterparts in public agencies, in a position to work on a more autonomous level, and are primarily responsible to individual clients. They have resolved the conflict regarding loyalty to the client and responsibility to society as a whole for social control in favour of the client. Stripped from the bureaucratic complexities of human service agencies, the social worker in private practice can select clients more carefully and pursue client needs to a much fuller

extent (Howe, 1980; Brown, 1990). Private practice has a major clinical emphasis. In this study, for example, 61% of the respondents had received clinical training. Social workers in private practice are however in a position to either specialize in clinical social work or render generic social work to individuals, couples and families, unencumbered by conflicting bureaucratic demands and constraints. Orten (1987) states that while the focal point in clinical work is on individuals with personal pathology, the necessary skills are characterized by expert knowledge, therefore requiring specialized training, which is usually taught in higher degree programmes. While clinical social work may be carried out under both public and private auspices, clinical social workers are professionally qualified at the autonomous practice level to provide direct, diagnostic, preventative, and treatment services to individuals, families, and groups where functioning is threatened or affected by social or psychological stress or health impairment (Meyer in Rosenblatt et al, 1983). Those who give preference to private practice have specific training requirements, a knowledge base, a code of ethics, licensing and its regulatory arrangements.

The social worker who is in private practice on a part-time basis and who is employed by an agency or allied setting, can proceed with services having informed the agency about it. The relationship between the agency

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activities and the private practice activities needs to be mutually agreed upon and contracted. This includes whether the particular social worker may receive referrals from the agency involved. Transfer of the client to the private practice should remain the client's right of choice. Social workers in private practice can also be employed by agencies on a consultative or sessional basis. Regarding inter-professional relationships, the social worker in private practice is obliged to adhere to professional ethical standards in an attempt to establish and foster a positive attitude towards the social work profession. Statutory guidelines for confidentiality is a prerequisite in working in collaboration with other professionals, e g psychometrists, nursery school teachers, doctors, lawyers, psychiatrists, etc. The client's permission needs to be obtained before information is shared, except under conditions when the client may be a danger to himself or others, or when the social worker may not be protected in a court of law when being subpoenaed (NASW Handbook on the Private Practice of Social Work, 1974, 28), (Social Work Act No. 110, 1978, South Africa).

Being a social worker in private practice has implications for the social work profession in general. Time-wise, quality service delivery to the client results because the social worker is free from administrative and organizational responsibilities. Another investment

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which private practitioners are in a position to make, is the rendering of a therapeutic service characterized by constancy and continuity to their clients. In private practice it is possible to remain within the parameters of the mutually acceptable contract between worker and client. Accountability to the client, rather than to the supervisor and the agency, is thus an integral part of service delivery. Private practitioners are not performing charity work but run a business within a competitive economic marketplace. Private practice therefore alters the context as well as the very nature of social work practice (Brown, 1990; Seiz et al, 1992; Butler, 1992).

The fields of service in which social workers in private practice work include the child and family arena, medical social work, court work, industrial/commercial/ management work, involvement in education and training, and groupwork therapy (South African Association of Social Workers in Private Practice Resource List, 1987).

The Council for Social Workers in South Africa delegated specific guidelines for private practice during 1987. These rules pertain to the following: The establishment of the Private Practice; organizing a Group Practice; contract setting within the worker-client relationship; relationships with social welfare agencies; interprofessional relationships and; record keeping. The same requirements in respect of registration with the

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Council for Social Workers that apply to social workers at public agencies, are applicable to those in private practice. To the usual system (prevalent in public agencies) of confidential record-keeping, consultation rooms ensuring privacy, and ongoing supervision by an experienced social worker, is added a system of financial record-keeping. The fees charged for professional services should be in accordance with the fee-structure suggested by the Association of Social Workers in Private Practice. In addition to contract-setting, the social worker in private practice should clarify times of availability to the client and prepare any given client on breaks in the service delivery. In relation to inter-professional relationships, the same professional ethical standards need to be adhered to. In conclusion, social workers in private practice are therefore required to uphold the very same high professional standards as expected of their counterparts in public and private agencies. The reader is referred to the handbook on guidelines for social workers in private practice for a full review of these rules as delegated by the Council.

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Private practice has its limitations with regard to several aspects. The individual is of prime importance, therefore implicitly assigning a secondary place to society. A fee is charged to the client, hereby making therapy available only to clients who can afford such services, to the exclusion of the poorer section of

society. However, by only catering for a segment within society who can afford the relevant fee involved, societal inequalities are implicitly reflected by the very character of private practice. In essence therefore, private practice only caters for certain clients who are predominantly from the middle class who require clinical management, while excluding the poor, who is also in need of and who can benefit from such services, yet find themselves unable to afford these services.

3.2. CLINICAL SOCIAL WORK: ITS MAIN FUNCTIONS, AND A CRITICAL LOOK AT ITS KNOWLEDGE BASE.

In this section clinical social work will be discussed in relation to its main functions as well as its knowledge base. This knowledge base will be examined in the light of claims made by several authors with regard to its fulfillment of its purpose.

Orten (1987) stipulates that the clinical social worker has specific functions, in accordance with the needs of the given society - be it an underdeveloped, developing or well-developed society. In South Africa as a developing society, industrialization and modernization is resulting in the weakening of extended family networks, hereby creating a need for another support system for individuals. Clinical social work serves to

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supply the needs of those who have become removed from their original family network due to greater mobility. The role clinical social work plays is to help individuals adjust to society. Firstly, it therefore serves a humanizing function in society whereby the needs of troubled individuals are being supplied. Secondly, clinical social work also monitors the ills in society because malfunctioning becomes evident first in the weak individuals in society. If these individuals are ignored, some of the severest problems in society will remain unattended to. Thirdly, clinical social work can benefit society at large by applying the knowledge and insights gained in practice in a preventative capacity. Fourthly, a boundary maintenance function is served by clinical social workers. By enabling individuals in therapy to rediscover their psychological boundaries had it become blurred due to weakened ego functioning, values and integrity of the individual are being reestablished, enhancing group - and community values as well as the intactness of society at large (Orten, 1987, 75 - 78).

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Goldstein (1980) questions the knowledge base of clinical social work, and calls upon clinical social workers to reexamine the knowledge they are using to establish whether the theories being used in practice coincide with the values of clients. Goldstein claims that practitioners do not have the necessary systematic

knowledge to engage with clients in a way to help them cope more effectively. She claims that the knowledge needed to create more adaptive transactions between the client and his environment through enhanced individual coping mechanisms is lacking because theories are not compatible with the needs of minority groups such as single mothers, blacks, lesbians, homosexuals, etc. The challenge of clinical social workers are therefore to become active in pursuing knowledge about the real problems clients have to cope with in life, as well as knowledge about effective intervention.

Dean (1989) challenges clinical social workers to reexamine the theoretical stances from which are being operated in practice by introducing the concept of personal knowledge changing the understanding of the use of theories. The notion that all knowledge is personal and non-existent without the personal participation of the knower, implies that it is impossible to separate what workers choose to know from their personalities because it make up their feelings, interests and prejudices. In order to come closer to the ideal which Goldstein proposes, Casement's (1986) suggestion about remaining open to learn from the client and experience the reality of the client's problem through his own frame of reference, belief system or worldview as proposed by Peck (1978), seems to be a case in point. Pray (1991) calls this the reflective model, because the client is

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actively involved in defining the problem, and continuing interactions with the client make treatment alternatives a reality in practice. Fleck-Henderson (1989, 130) agrees that " the more holistic or insight-oriented the clinical approach, the less practice is an application of theoretical principles", implying that theory should enrich clinical intervention by serving as conceptual tool to best serve its purpose.

For the purposes of this study, clinical social work can be defined as the assessment of the interaction between biological, psychological, social and spiritual forces in the lives of individuals, couples, families, or groups with similar needs, and the clinical intervention with the given client(s) with the ultimate goal of restoring the ego-functioning at its optimum level through the equipping of the person(s) with appropriate coping mechanisms to best deal with their current circumstances. This definition encompasses all aspects which need to be taken into account regarding intervention with the HIV- infected and the AIDS-patient, therefore appropriating an holistic approach. One shortcoming of this definition is however that it does not make provision for the common occurrence of reworking old meanings in extended treatment with the AIDS-patient and the significant others.

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3.3. THE ROLE OF THE SOCIAL WORKER IN PRIVATE PRACTICE (WITH A CLINICAL EMPHASIS) WITHIN THE AIDS-ARENA.

AIDS falls into the parameters of clinical social work in several ways. These parameters include individual work with the HIV-infected and AIDS-patient, family work, helping define what constitutes both a diagnosis and treatment objectives, teamwork, group therapy, being comfortable with the use of a biopsychosociospiritual model, preventative work, supervision or consultation, and the influencing of welfare policy where necessary concerning human rights, in strict adherence to social workers' code of ethics.

3.3.1. THE ROLE WITH REGARD TO THE HIV-INFECTED - AND AIDS- PATIENT.

3.3.1.1. THE ROLE IN TERMS OF THE STAGES OF INFECTION

Social workers can provide appropriate treatment, given the different stages of infection. According to Miller, Green and McCreaner (1986) five different groups require counselling:

(i) The "worried well" persons. These persons have not been tested sero-positive but live in fear of having contracted the virus through some exposure to it. Those requesting screening need to be counselled by the social

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worker before being tested, to allow them to make informed decisions. If the outcome of the test was positive and the person's medical status became known, he/she may well run the risk of losing a job and/or face strain in relationships. Education is therefore a major role the worker carries out in order to provide cognitive facts about risk reduction as well as dealing with the consequent emotional outcomes of the client.

(ii) Those who have tested positive but are still asymptomatic. They require post-test counselling in the form of education about prevention regarding spreading the infection, as well as about the course of the illness. The social worker also has to examine historical information supplied by the patient and link unfinished business of the past into the present to enable the patient to cope with the present circumstances. This is necessary to assist the patients in managing anxiety and insecurities concerning whether and when they will develop full-blown AIDS.

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(iii) The people who are seropositive and symptomatic. They require post-test counselling by way of education, like the previously discussed group. It needs to be combined with anxiety management as well as management of depression. The social worker has to focus on issues pertaining to possible losses for the patient, which may include the fear of becoming isolated from family and

relatives, possible rejection from a lover(s), loss of friends, being retrenchment from work, the loss of future ideals, and the loss of physical strength. Countertransference feelings such as helplessness by the social worker may serve as helpful in engagement with the patient at this stage of treatment.

(iv) Those who have AIDS and AIDS Related Complex(ARC). Assistance with long-term adjustments is required. This aim can be achieved through coordinated services among the disciplines. Issues which the social worker has to bear in mind include the arrangement of a supportive network to provide the necessary transport regarding the patient's visits to the hospital or doctor, the appointment of a suitable caregiver in the community once the patient becomes bed-ridden, etc. During this phase of therapy, the social worker has to help the patient accept and come to terms with the current circumstances of increased dependency and reliability on others for care and enable the patient to accept the decreasing physical strength and bodily manifestation of the illness by focussing on the symbolic meanings of these changes to the patient. Issues such as self-esteem and self-confidence may require increased focus at this stage. The meaning of death also has to be explored in terms of the significance thereof for the patient. The resolution of anger against God and former lovers may surface, and needs to be dealt with to enable the patient to accept

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the reality of death and find inner peace about its finality.

(v) Family, friends and lovers. Emphasis is placed on the fact that the lovers have fears regarding their own antibody status because they may in a sense 'share' the diagnosis. Pre-test counselling is required in this instance to examine possible outcomes of testing should the lover decide to be tested for HIV. Supportive counselling and post-test counselling as a follow-up to testing should include risk-reduction for the person who was tested negative. Prevention of the spreading of the virus should be focussed on in case of the person who tested positive. Family and friends may struggle with feelings of anger with the patient or others, disbelief with the reality of the situation, depression over the inevitability of the loss in future, etc. They need to be enabled to face up to and acknowledge as well as grow towards acceptance of the circumstances to become a positive influence in the life of the patient. Unresolved issues from the past have to be addressed with the patient, should the social worker regard it as necessary in the final analysis, to assist in the achievement of this goal.

In the next section the psychosocial impact for the "worried well"-group through to those who have full-blown AIDS, and the different crises involved in this

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developing process from being asymptomatic to the facing of death, will be looked at in greater detail in terms of the developmental phases as each one of them requires different issues to be focussed on by the clinical social worker in therapy with such a patient.

3.3.1.2. THE ROLE WITH REGARD TO THE PSYCHOSOCIAL STAGES

Many psychosocial stressors impinge on the ego and influence the ego-functioning of the AIDS-patient. Rounds et al (1991) identify some of these stressors as including altered social roles due to social ostracism, rejection, and isolation; the loss of control over and destroyed future expectancies; and fear of death.

The psychosocial impact of HIV and AIDS on the individual is divided into five phases by Weyers (1990):

- **Phase 1 : Fear or denial**

  Individuals who partake in high risk activities fear infection while those who regard themselves as being at low risk, ignore the possibility of becoming infected.

- **Phase 2 : Emotional disorganisation**

  Despite the kind of lifestyle led prior to having been tested positive for HIV, the infected person usually

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experience the reality of having contracted the virus with shock and disbelief. Emotional disorganisation follows, and is manifested in feelings of acute fear of death and rejection, anxiety, shame, guilt, denial and depression. The individual will seek medical solutions for his/her condition, and project the reason for being infected on outward circumstances beyond his/her control.

- **Phase 3: Changed roles, losses and isolation**

As awareness of the person's infection increases and the illness becomes evident to others, the third phase is entered, which is the symptomatic stage of the illness. It is marked by the person, who is now an AIDS-patient, being compelled to take on the role of social outcast and being a patient. The male patient also looses his job and role as breadwinner, as well as the security of insurance. The greatest impact in this phase do however lie on the level of social isolation. In case of being married, rejection by the marital partner may occur. Rejection by family, friends and other support systems may also become a reality.

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- Phase 4: Acceptance or anger

In the majority of cases the individual accepts the diagnosis and the inevitability of death and plan the time left to be enriching and meaningful. The group of AIDS- patients who cannot accept their condition harbor anger against society for the rejection and emotional trauma involved in their condition, anger against God for allowing the existence of AIDS and their contamination with it, and anger towards themselves. Depression and suicidal ideation follow. The powerful feeling of anger against society leads to the purposeful increase in sexual activities to infect others.

- Phase 5: Death

At this stage the therapist deals with a full-blown AIDS-patient. This phase involves termination with all those closest to the patient. It may include completion of all unfinished business of the past, in order to die peacefully as an integrated human being.

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Throughout therapy the social worker therefore has to deal with different issues in the life of the patient at different stages, in close association with the development of the disease. It ranges from the initial

fear of having been infected, the blocking out of the possibility of having contracted the virus as well as denial of the reality of the circumstances once the diagnosis has confirmed the patient's worse fears, through to projection of anger by the patient about his/her condition onto lovers, society and/or God. It is apparent that as bodily symptoms manifest, different losses occur, leading to social isolation as well as an increase in symptoms of depression. In the final analysis, the social worker has to help the patient to accept all the inevitable consequences of the illness, enable him/her to work through 'unfinished business' of the past with relevant persons as well as terminate with significant others, to finally, acceptance of death.

Several crises do however also occur in the life of the patient as the illness progresses (Isaacs et al, 1992). To these the social worker also needs to be sensitized, to enhance successful therapeutic intervention. This will be dealt with in the next section.

3.3.1.3. THE ROLE REGARDING RECURRING CRISES

Due to the fact that AIDS results in recurring medical crisis in the life of the patient in the form of repeated opportunistic infections, the crisis element in the HIV-range is another factor to be reckoned with throughout treatment of the patient. Caplan (Golan, 1978) states

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that " a crisis occurs when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilization of his customary methods of problem-solving."

Kfir (1989) developed this definition further by explaining that three aspects are characteristic of a crisis. Firstly, a lack of information, which is linked to a void being felt about a radical change in the life of the person. As a result, the usual coping mechanisms fail and new ones cannot be developed soon enough to restore the inner balance. The past becomes a dream, the present a painful experience that cannot be avoided, and the future an anxiety-provoking thought. Secondly, aloneness sets in as a result of a lack of support. The person's social circle where he/she felt a sense of belonging, collapses. Those who are present are not recognised in the sense that the person becomes withdrawn and unable to reach. Thirdly, the reality of a lack of options grows in the mind of the person as he/she cannot see any future for himself or herself. This aspect is resultant from the regression to concrete thinking where the feeling is generated that no options or choices are available. Emotional shock, anger, and pain and grief therefore follow each other in the stages of the crisis - from being inaccessible and out of touch with others, to reintegration in the form of grieving.

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With regards to dealing with crises in the HIV-range, Golan's (1978) model complements Kfir's (1989) description, in that she highlights loss, threat and challenge, and an opportunity for growth as inherent components. Isaacs and Miller (1985) emphasizes the fact that anxiety forms part of each of these three stages. They add that in the life of the AIDS-patient losses may include loss of a son, a friend, a lover, the security of a job, health and freedom. Threat could surface with regard to being isolated as a result of the illness, being discriminated against in the workplace due to homophobia and/or fear of contagion, or perhaps the possibility that the sufferer will die. The assumption that crises in life are indeed unavoidable and should be regarded as opportunities for growth and a resultant deeper, more creative perspective on life, leads to the conclusion that the challenge for the AIDS-patient is to consider the quality and intention of his/her sexual relationship(s). Isaacs (1987) added that pertaining to the crisis-element, the "worried well" and those with AIDS Related Complex are in particular need of crisis psychotherapy.

Isaacs and McKendrick (1992) examine the AIDS crisis according to Golan's stages with specific reference to the homosexual patient but the treatment proposed by them is equally useful for intervention with AIDS-patients who are not of a homosexual orientation.

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- Initially, the hazardous event has to be identified before any assessment or therapeutic intervention could be proceeded with. The reason being that the presence of the virus had not been anticipated, resulting in denial by the patient. For the homosexual patient there are several interpretations of the hazard, ranging from the negotiation of the whole process of establishing a homosexual identity, to a generalized homophobia.

During intervention, the social worker needs to be aware that the hazard is synonymous with feelings of anger, resentment and envy regarding a sexually 'safe' lifestyle prior to the diagnosis of AIDS. The therapist has to explore whether any significant episodes in the past of the patient, in terms of its interpretation by the patient, relates to 'unfinished business'.

- Secondly, internal and external events and/or processes determine the degree of the vulnerable state. Specific reactions to the hazard include feelings of anxiety and anger relating to the illness as well as the treatment thereof, fear of social abandonment, and guilt due to the perception that AIDS is a retribution.

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Stulberg and Smith (Isaacs et al, 1992) suggest that therapeutic intervention take account of specific psychological issues, ranging from shock, anxiety and fear, depression, frustration and anger and guilt, to obsessive disorders. These issues which are evident in the vulnerable state seem to encompass the totality of the crisis for the AIDS-patient. It is indeed this phase that gives the therapist access to hidden fears and unresolved issues from the past because the defense structure of the patient is weakened. It is however important to note that the potential gain which forms part of this vulnerable state is usually minimized as a result of the all-pervasive obsession with the illness itself. It is therefore suggested that this tension has to be diffused in therapy to become focussed on opportunities for gain flowing out of the situation for the patient.

- Thirdly, the precipitating factor in an AIDS-crisis may be a single hazard or a few. Yet, it is of diagnostic significance because it allows the therapist to begin to understand the crisis. It can also be traced back to past episodes as well as recent circumstantial events.

Therapeutic intervention has to focus on enabling the patient to re-experience the peak of tension in the

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crisis. The patient has to be helped to partialize and focus on the salient features of the crisis. Individual reactions to stress results in differing approaches to the precipitant. Assessment should therefore consider issues such as the validity of the precipitant, the person's ability to deal with AIDS panic, the severity of stress factors, the person's internal frame of reference, and a clinical understanding of the person's defense structure. The therapist is also alerted to the fact that the diagnosis of AIDS may serve as defense to avoid the process of coming out of the closet. In this instance it is safe to discuss safer sex practices while pursuing reactions to safer sex objectives.

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- Characterised by being a fluctuating process, the state of active crisis extends its focus to the feelings of anxiety and panic as well as the multiple losses associated with the disease. It also addresses the question about the effect and necessary consequences of physical disfigurement and death. Due to arising internal and external stress, the active crisis remains inseparable from the other stages of crisis. Important to bear in mind as therapist is that the accumulated losses trigger suicidal ideation incomparable with that of patients suffering from other terminal illnesses such as cancer.

In intervention, all the factors contributing to the crisis have to be examined, assuming equal importance to them all, to prevent the patient from conveniently ignoring some of the relevant issues. Of importance is that this stage encompasses material from the past, the present, as well as the future. The therapist therefore has to focus on matters involving a wide spectrum, which could range from self-esteem, to the physical, to the sexual. Simultaneously, the clinician's main objective would remain to restore a sense of equilibrium.

- **The stage of reintegration** follows upon the state of active crisis at the stage when relief and hope have resulted. A level of acceptance of and adjustment to the inevitable circumstances of the here and now and unknown future characterises this stage.

At this stage of intervention, the clinician has to separate the patient's perspective on the reality from the complicated nature of the symptoms of the illness. This is necessary to ascertain whether the diagnosis is correct and was indeed confirmed by a medical doctor, if the diagnosis has perhaps changed because the symptoms had reverted from AIDS to ARC, and for which diagnosis had the patient been receiving treatment.

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Furthermore, a team-approach is called for to enable the social worker to deal with the dependency needs of the patient, and remain focussed instead of being side-tracked by transference and countertransference issues. In the final instance, the therapist's role in reintegration has different focal points given the nature of the diagnosis. In the case of an AIDS patient, the themes of death and dying as well as termination will dominate therapy, while those who are HIV-positive and those who have ARC have ongoing and fluctuating needs.

The social work intervention proposed by Isaacs and McKendrick (1992) emphatically underlines the importance of clinical skillfulness in dealing with patients in the HIV-range in terms of engagement, sound assessment, identification of the needs in any given phase of the crisis, and successful treatment of these patients. More importantly, however, it calls for an in-depth understanding of the illness in terms of its clinical manifestation and development into full-blown AIDS in order to best serve the needs of the patients being treated.

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3.3.2. THE ROLE WITHIN THE FAMILY.

3.3.2.1. THE FAMILY UNIT.

HIV and AIDS is the very first disease among chronic and terminal illnesses that have created the need for the redefinition of the members within a family in terms of role expectancies and ensuring civil rights of families. The fact that members within the family unit faces fear of isolation, transmissibility, stigma, as well as confrontation with their own sexual behaviour and drug abuse, result in tension which hinders constructive communication and problem-solving within the family system and the wider community. The AIDS-patient within the family unit's experience of attack, judgment and isolation from other family members and the broader community, becomes an experience which is shared by all the other family members involved. These insights were developed by Leukefeld and Fimbres in their clinical practice, suggesting that emotional, developmental and other concrete difficulties resulted from lack of community support services to the whole family unit (Newmark and Taylor in Leukefeld et al, 1987).

In cases where the patient is a homosexual, the family is confronted with two crises if they only learn about the homosexuality of the family member at the point where he can no longer remain in the closet, i e usually during

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the symptomatic stage of the illness when AIDS is diagnosed, and is compelled to share the diagnosis with loved ones. The clinical social worker needs to focus family work on feelings related to the homosexuality of their child and brother before intervention can proceed on the level of the crisis in terms of having a family member with AIDS. Strommen (1989-1990) suggests that parental reactions consist of two main facets: the feeling that their child is different, from another species, a total stranger to them and; a strong feeling of guilt and failure. Feelings of loss need to be focussed on in therapy with regard to mourning the death of a child's identity which they have believed existed because the impending loss as a result of the terminal nature of the member's illness need to be dealt with as well. Robinson et al (1989-1990) add feelings of anger over sexuality of member, embarrassment, disgust, depression, shock, bewilderment, disbelief and hurt to what need to be explored in therapy in this regard.

Once family members have overcome the denial and secrecy involved in the simultaneous disclosure of having AIDS and homosexuality in case of a gay patient, the clinical worker can facilitate the development of a caregiving system. McDonell et al (1991) propose a psychosocial model in which they identify three burdens the caregiver faces:

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(i) assuming the daily responsibilities of the patient;

(ii) disruption of the caregiver's own routine;

(iii) the need to find a balance between the needs of those family members who are well and the member who is ill.

This psychosocial model operates from the premise that assessment is aimed at anticipating the possible caregiver's responses to the current and future needs of the patient. Projections can hereby be made about the establishment of a successful caregiving relationship, and whether such a relationship can be sustained over time. Assessment has to include the willingness to care for the instrumental needs (e g provision of transportation for medical input), the emotional needs (e g listening to the expression of feelings like guilt and anger), and the physical needs (e g bathing the patient) of the ill family member (McDonell et al, 1991).

Predicting willingness to care for the ill family member relates closely to three factors as outlined by McDonell et al (1991:46-47): Firstly, caregiver resources that may be called upon to help meet the challenge include environmental (e g religious activities may help alleviate some of the stress involved in the role),

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family (e g the actions of family members may impede the caregiving arrangement) and personal (e g flexibility in the face of changing circumstances) attributes. Secondly, coping characteristics include the behavioral and thinking patterns in direct response to the question of caregiving. Thirdly, perceptions and judgments indicate the meaning of the challenge, and the adequacy of environmental resources to help meet the demands involved in caring.

The role of the private practitioner with reference to the family encompasses various aspects. If the family presents with the crisis of learning that their child and brother have AIDS, while at the same time appears to be startled by the discovery of his homosexual identity (in case of a gay patient), family therapy would need to explore all the feelings related to the patient's coming out of the closet first of individual family members. The therapist has to provide the necessary support while acting as the mediator in helping members to share these feelings with each other. If communication had broken down due to the crisis, the therapist can act as link via whom the inner turmoil becomes shared. Anger, shock, disbelief and an inability to know how to relate to the patient, may surface in therapy.

Furthermore, the clinician has to help facilitate the mourning process over the loss of a child and brother's

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sexual identity, and lead them towards acceptance thereof and hereby also acceptance of the patient. Having successfully dealt with this crisis, family members can then be enabled to deal with feelings related to the illness itself, its meaning to them, and how it affects their own functioning within the family as well as in the community. Factors negatively impacting on communication among family members may need to be addressed within therapy as well to help restore their previous level of family functioning. Subsequent to having dealt with their fears of transmissibility, rejection and isolation from the community, the mourning of the loss of the patient due to the terminal nature of the disease is important at this stage.

When the family enters therapy, the themes and meanings of the illness to members as well as what the family member who has contracted it has stood for within the family, needs to be explored first. This knowledge will guide the clinician in relation to further intervention and management because the patient may fall anywhere within the HIV range and not necessarily be terminal. The clinical diagnosis will determine the focus of intervention for the private practitioner.

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3.3.2.2. WOMEN.

Women with HIV and AIDS and mothers with children who have AIDS, are also in need of intervention to help cope with the realities they have to face up to. These women suffer rejection and isolation in the community. It results in withdrawn behaviour amidst a desperate need to be accepted as a human being. Support groups for these women have proved to enhance coping skills as self-acceptance grew, within the therapeutic atmosphere where needs were being met (Kubler-Ross, 1987).

Women who become HIV-infected and contract AIDS are not only treated with suspicion but also blamed by society for infecting children when in the role of mother, or infecting men when they are prostitutes. These judgments oppress women and further the spread of HIV and AIDS (Stuntzner-Gibson, 1991).

These factors in relation to women have specific implications for the private practitioner who stands challenged to intervene when required to. Of utmost importance is to assess the ego-strength of the person as well as the coping mechanisms involved in dealing with the stressful life circumstances. The practitioner has to focus

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on the adoption of coping mechanisms that will enhance functioning of the individual, due to the strong need for acceptance by significant others as well as the broader community. Strong emphasis has to be placed in treatment on the growth of self-acceptance to lessen dependence on the community, so as to provide a platform for self-acceptance by interacting in an accepting way.

The mother's feelings towards the baby have to be explored as well to ascertain whether the negative experience with significant others and the community has become projected onto the child. This intervention may also be approached through use of Golan's crisis model, especially in terms of leading the women towards hope for the future and a challenge to become the nurturing mother which she perhaps always longed for during her own childhood. Unfinished business from the past which may have led to a promiscuous lifestyle can be dealt with by turning it into a positive incentive regarding time left being well-spend with the child, should the mother be terminal.

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Case management with a sex worker would need to address the theme of safer sex practices and, bearing in mind the diagnosis in the HIV-range, proceed with therapy in terms of the needs and issues pertaining to individual circumstances. The detailed approach will be in strong adherence to the intervention specified earlier on in

this chapter in relation to the different phases with which individual patients may present, ranging from the "worried well" to those with full-blown AIDS.

3.3.2.3. CHILDREN AND ADOLESCENTS

A subsystem within the family system which needs focussing on, is children. Signs and symptoms of AIDS in children include the failure to thrive, recurrent bacterial infections, thrush, lymphadenopathy, and chronic intersitial pneumonitis which is the only disease recognised as full-blown AIDS in children. Adequate nutrition is made difficult by inflammations like thrush, resulting in impaired growth. Cognitive impairment leads to delayed achievement of developmental milestones. Regression may result, e g crawling (Chachkes in Leukefeld et al, 1987).

These children who contract AIDS have to cope with ostracism, rejection and social isolation resulting from public fear. Feelings involved in hospitalisation as a result of deteriorated health include that of being separated from the family, pain and discomfort as well as fear resulting from medical procedures involving medical staff and visitors wearing gloves and gowns. The social worker needs to remain sensitive to these needs of the child, and sensitize family members to it. This may include addressing their own feelings and fears regarding

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contact with the ill family member (Chachkes in Leukefeld et al, 1987; Kubler-Ross, 1987).

Adolescents frequently experience feelings of anger because they are felt to be discriminated against due to AIDS, the incurable nature of the disease, as well as due to loneliness and the thought of a painful death. They also suffer guilt as a result of previous lifestyles and the possibility of having transmitted the disease to others. This powerful feeling results in the patient experiencing helplessness, sadness, hopelessness, isolation, depression and the contemplation of suicide (Lockhart & Wodarski, 1989).

3.3.3. THE ROLE IN DEFINING TREATMENT OBJECTIVES AND WORKABLE DIAGNOSES REGARDING SYMPTOMS AND/OR SYNDROMES

HIV and AIDS falls into the parameters of social work practice in terms of defining treatment objectives after having created workable diagnoses resulting from insights developed as practitioner. In a study performed by Berner and Kufferte (1982), the need for differentiation between symptoms and syndromes regarding the fear of AIDS in premorbid personality were stressed. Due to the confusion over whether the fear of AIDS is a psychiatric symptom or syndrome, engagement in therapy coupled with research to find clarity in terms of its clinical

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implications seems to be a definite need, to help arrive at the appropriate form of treatment. The literature presently seems to conclude that psychiatric diagnoses in terms of psychophathology, still remains controversial (Segal, 1988; Lipkin, 1988). The difficulties in arriving at appropriate treatment methods are indicative of a lack of certainty in describing psychiatric problems.

It becomes clear that clinical social workers could help contribute in arriving at a workable definition of psychiatric disorders associated with HIV-infection, resulting in appropriate treatment interventions, as response to the psychological and social impact of HIV/AIDS. In 1987 Zlotnik already highlighted the multi-faceted nature of the AIDS-epidemic psychologically speaking. Zlotnik specifically addressed the fact that the psychosocial stress related to psychosocial adjustment by the AIDS-patient may well interfere with medical treatment and the person's ability to function at an optimum level. Since, the cry has moved beyond this point, to studies on appropriate intervention modalities (Karp, 1989).

Contrary to Freud's (in Jones, 1959) initial view of the therapist's feelings being an obstacle in the treatment endeavor, studies by Heiman (1950) and Beitman (1983) on countertransference have highlighted its therapeutic and

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diagnostic value in therapy. In the rendering of therapeutic services to the HIV- and AIDS-patient, countertransference issues are of an intense nature. Professional self-awareness and consultation on the meaning of these feelings can however pave the way for the realisation of its therapeutic value. Only then can these issues serve as important tools for diagnostic assessment and treatment objectives with the patient concerned (Dunkel and Hatfield, 1986).

Leukefeld et al (1987) and Almond (1990) proposed focussed treatment interventions with populations who have specific needs. It includes working with the following groups: prostitutes regarding safe sex, STD patients regarding HIV-prevention, adolescents regarding early onset of sexual activity and its implications, and workplace programmes where literature is distributed.

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3.3.4. THE ROLE IN TERMS OF TEAMWORK

Clinical social work practice has a responsibility regarding the AIDS-pandemic in relation to teamwork. In 1986, dr Ronald Mitsuyasu, a physician at UCLA, declared:

> "A positive attitude is critical when dealing with any kind of serious disease. There is a lot we don't know about the correlation of AIDS and the immune system and the psyche."
>
> (Hancock et al, 158)

Hancock (1986) also states that physicians are realizing that an essential physical and psychological hindrance to people accepting the fact that they have contracted AIDS, is closely linked to their acceptance of their sexuality. With the result that they become withdrawn, isolated, depressed and even bitter. Staley (1991) explores this in terms of the role the social worker can play in a teamwork-capacity to increase the quality of care given by the physician to the patient, to negate the view that it is a so-called difficult patient, when indeed the patient has issues which need to be worked through in counselling.

Fear of contagion with AIDS has emerged as the primary concern in a number of surveys of health care professionals (Pleck, 1988; Wallack, 1989; Gallop et al, 1992). This is experienced by the infected person as an extension of the social ostracism of the community. It reinforces the feelings of anger, discrimination, rejection and isolation of the patient. In this regard the clinical social worker is in a position to therapeutically engage with the professional and explore the feelings involved in the

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prevalent fear of contagion, enabling the person to render more empathic services to the patient.

Nugent (1992) reiterates the role that the clinical social worker can play via interviewing style, thereby making an effective impact on the patient. He illustrates it with some single-case experiments. In essence, the realization has dawned that efficient and compassionate medical care to HIV-infected people and AIDS-patients needs to be combined with a meeting of the social needs of patients, such as emotional support, financial information, and the involvement of friends and family members (Cleary et al, 1992).

3.3.5. THE ROLE AS GROUP THERAPIST

Group therapy as treatment modality for the HIV-infected - and AIDS-patient cannot be underestimated due to its role in the holistic treatment of the AIDS-patient.

The provision of social support on an emotional, practical and informational level has been found to decrease the likelihood of depression of gay men a year later (Hays et al 1992). Homophobia and fear of contagion decrease the extend to which the infected person can expect to receive satisfied social support within the community, challenging the group

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therapist to create the therapeutic milieu to help meet these needs.

Gambe et al (1989) suggest a group therapy model which has been designed to meet the special needs of HIV- and AIDS-patients, which is why it is distinguishable from any other groupwork model. The emphasis is on group therapy within a context of other supports, like social services, income maintenance, family, friends, etc. The model needs to take account of the periodic crises of group members, which is not accounted for in the crisis model of Naomi Golan because it expects the maintenance of problem-solving reactions over an indefinite period of time. But because AIDS is a fatal disease this activity cannot be maintained by the member.

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According to Getzel (1991) people with AIDS in groups use different survival modes to enable them to cope with the challenges involved in having the disease. There are four such solutions:

- **The Beneficent type**

  It is characterised by the need to be loving and kind in order to be remembered as a good person. It is a way of undoing unlikable characteristics within the self.

- **The Heroic type**

  It is characterised by a call to combat AIDS as an evil foe through private thoughts and private activities.

- **The Artistic-Spiritual type**

  Characteristic of this type of solution is its regard of the self as enduring an experience beyond death through faith in man's immortality.

- **The Rational-Instrumental type**

  This type of group member lives only one day at a time, while seeking validation for information in science. These members are usually up to date about most recent treatment breakthroughs.

These solutions, once identified as used by different members, can be utilised by the group worker to encourage appropriate solutions to members in terms of how to cope with the realities involved in having AIDS.

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3.3.6. FOCUSSING ON ISSUES RELATED TO DYING, AND DEATH ITSELF

Clinical social workers are called upon to become comfortable with a biopsychosociospiritual model in the treatment of AIDS-patients because they are working within the realm of a terminal illness, i e when AIDS is clinically defined according to definition. According to Shernoff (1990, p 7) as quoted by Cornett (1992):

> "A dying young person can challenge personal and societal myths of what constitutes a good death. AIDS challenges social workers to change themselves by dealing with feelings about pain, illness, death and the illusion of personal immortality."

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De Bruyn (1990), Van Niekerk (1991) and Winiarski (1991) agree with this, the theological consideration, as part of holistic treatment. The therapeutic engagement with the terminal AIDS-patient focuses on the person's feelings involved in facing death, what death means to the patient, and the expectations involved as well as introducing the patient to death in all its realities once the phase of denial has been worked through. In essence the clinical social worker is required to communicate an attitude of caring and compassion as theological underpinning, which

encompass basic social work skills of empathy and a non-judgmental attitude within the therapeutic milieu. This attitude will enable the patient to address bitterness and anger in the safety of a therapeutic environment with a therapist who is worthy of being trusted instead of feared to judge the patient because a hostile environment will further anger against God instead of enhance growth towards an integrated dying experience. Cornett (1992:101) states that the use of this model within therapy will open up opportunities for "tremendous growth that clients could achieve through exploration of the spiritual aspects of their lives".

Cornett's (1992) suggestion to become familiar with a biopsychosociospiritual model in intervention with the AIDS-patient, is a relatively new development in social work as profession, therefore rendering the writer incapable of elaborating in more detail on the model. As this proposed model of Cornett (1992) does however become widely known and is adopted by social workers into their treatment repertoire with AIDS-patients, subsequent literature could be expected to provide more detail on the application thereof. Until then it is suggested that the role of the clinician with regard to the issue of death also take account of current literature.

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For people who are suffering from AIDS, the traumatic experience has brought home the realisation that there are circumstances over which man has no control. AIDS being a terminal illness, the AIDS-patient cannot escape the associated phases prevalent in negotiating the inevitability of death. Due to the fact that not all HIV-positive persons do eventually develop full-blown AIDS, the stages in negotiating the illness as proposed by Kubler-Ross (1969) have to be used with much caution in treatment by the social worker to suit the needs of the patient. The stages within the model on death and dying as identified by Kubler-Ross (1969) include, in succession, denial and isolation, anger, bargaining, depression and eventual acceptance. However, the psychosocial stages outlined earlier in this chapter (see 3.3.1.2.) are comparatively more useful as tool to guide the social worker in therapy on the theme of death, in close association with the proposed biopsychosociospiritual model. Knowledge on AIDS as an illness that may progress differently for individual patients, mainly because some patients never develop full-blown AIDS, has led to the conviction that the disease cannot be therapeutically approached via the same route as other terminal illnesses.

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3.3.7. INFLUENCING POLICY WITH REGARDS TO HUMAN RIGHTS

Since the AIDS-crisis emerged in South Africa, the government's health and welfare policy has reflected a biased attitude towards the complexities involved in the contraction and spread of the disease. This bias regarded AIDS as a Gay disease and an African disease. In essence, the sexual transmission of the disease is minimised in an attempt to hold onto this bias (Isaacs, 1991).

Closely linked to this gross misinterpretation, the racial inequalities reflected in the government's social welfare policy are founded on colonial and first world models which do not meet the needs of the economic, political and cultural realities of South Africa (Patel, 1991). Furthermore, privatisation combined with governmental control in the form of the Fund Raising Act, the allocation of grants, and subsidization of social welfare agencies, have resulted in an unjust welfare framework far from the ideal of a unitary welfare structure.

Democracy and justice are values which are central to the social work profession. McKendrick (1990) notes that both the formation and the introduction of changes to a welfare system are political processes. With the current political changes sweeping South Africa as the country

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moves toward a democratic and just society, clinical social workers have a vital role in the formation of a social welfare policy which will be equitable, and protect minority rights like those of homosexuals.

Against this background, the diversity in ethnicity in South Africa poses a unique challenge to clinical social workers to identify and serve as advocates regarding the needs of minorities who have contracted AIDS. Jue (Leukefeld et al, 1987) emphasizes the need for an understanding of the worldview of the client to grasp its influence on behaviour, such as apathy or denial in response to having contracted the HIV-virus.

Given their clinical skills and expertise, clinical social workers are in the position to pose recommendations regarding the protection of human rights via means like the presentation of scientific research results in a plea for social action and preventative services being instituted on grassroots levels to negatively impact on the spread of AIDS. Awareness campaigns, educational facilities and counselling services regarding the illness have been seriously neglected in remote areas. This has led to the rapid heterosexual spread of AIDS amongst Blacks in South Africa because they live outside the inner ring of the cities, rendering these facilities within reach of mainly white patients. Insights regarding the important

correlation between the containment of the spread of AIDS and an understanding of the nature of human sexuality as well as the issue of death (Pegge, 1988), have credibility if communicated by clinical workers familiar with issues of human sexuality. Use of the mass media as powerful tool in communicating information on AIDS to the public is of relevance in this regard as well (Reardon and Richardson, 1991). The education and training of clinicians therefore place them in a unique position in terms of contributing to future legislature concerning welfare policies in South Africa.

3.3.8. PREVENTION OF THE SPREAD OF HIV AND AIDS

Several studies focussing on strategies to reach risk groups in the prevention of the spread of HIV and AIDS (which do not fall within the parameters of this study to be discussed) suggested methods ranging from mass media coverage of the effects of AIDS on the lives of its victims, to the distribution of pamphlets by community resources as a result of the importance of education regarding the topic (Flora & Maibach, 1990; Freimuth et al, 1990; Bowen et al, 1990; Icard et al, 1992; Gold et al, 1992; Romer & Hornik, 1992). In a study by Silverman et al (1992) the assessment of different communication formats, led to the conclusion that conversational strategies in individual counselling regarding safer sex practices hold the prospect of greater change in

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behaviour than only absorbing information and listening to advice. The clinical social worker is therefore in the position where target groups like the "worried well" can approach him/her, for effective intervention on a preventative level.

Another target group are employees. Law makers and employers are in agreement that AIDS poses a very serious economic threat because health care expenses and a decreased production rate is an imminent reality. Prevention of the spread of the virus in the workplace, has become the desperate plea. This followed the realisation that direct (e g laws restricting sodomy, prostitution, extra-marital sexual intimacy and intravenous drug use) and indirect coercive measures with regards to employees will result in a public health disaster. Employees will be undermined in their willingness to come forward for voluntary testing (Dancaster et al, 1990; Sing & Moodley, 1990; Schutte, 1990; Cameron & Swanson, 1992). By shifting the focus from high risk groups to high risk activities, social workers will be in a position to render preventative services via individual work, small group forums and seminars using relevant clinical material. Summers (1991) adds that work also needs to focus on the creation of an attitude of tolerance on the part of co-workers of AIDS-sufferers, in which case a combination of educational programmes and individual work is required.

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This input is necessary because the results of a study performed by Summers indicated that both knowledge of AIDS and attitudes towards homosexuals were significant predictors of the willingness of workers to accept a co-worker with AIDS (Summers, 1991).

3.3.9. THE ROLE AS SUPERVISOR/CONSULTANT OF A SOCIAL WORKER THERAPEUTICALLY ENGAGED IN THE AIDS-ARENA.

Supervision in social work has remained relevant as tool within the profession since its beginnings in 1869, due to its continual adaptation to and reinterpretation of theoretical developments in social work as they occurred over the years. After its beginning as an educational device, supervision evolved into a practice tool, then became a therapeutic method, and eventually became a separate entity from therapy (Rabinowitz, 1987).

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Social work supervision originally had three main functions: administration, education and support (Kadushin, 1976), of which the administrative function seems to dominate the supervisory role in bureaucratic agencies even today (Poertner et al, 1983). Evaluating the role of the supervisor from a Gestalt perspective, Serok et al (1987) regard these three functions with equal importance as combination in a holistic learning process for the recipients thereof due to the argument

that these aspects together form a whole which is greater that the sum of its parts. It does however remain clear that although different theoretical approaches to supervision are prevalent today, including amongst others communications theory and ego psychology (Webb, 1983; Freeman et al, 1987), the objective remains intact, namely that of the growth of the supervisee through the three functions as stipulated by Kadushin (1976).

Given the immediacy of its impact, supervision has as its rationale the fostering of a process of professional training of the social worker. Amongst others, Serok et al (1987) emphasises the necessity of a trusting relationship within the supervision context between supervisor and supervisee, a focus on the roles and responsibilities of the supervisee, as well as a professional review of current cases. Furthermore, Serok et al (1987) reiterate the fact that by way of its very nature social work entails the development of a relationship, inevitably involving transference and countertransference issues. The unconscious, projective material of the supervisee then becomes the focus as the supervisor leads the worker into awareness of its existence and examines its influence on therapy with the given patient. In addition to this rationale for supervision, the mere fact that current therapeutic approaches underline the all-encompassing involvement of the worker (i e using cognitions, emotions, environment

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and the person in his/her totality) and an encouragement to extend therapy beyond theory and intellect, intensifies the therapeutic relationship and risks the loss of objectivity. As a second party, supervision acts as objective assistant in analysing and evaluating the therapeutic process. Finally, the supervisor also has a role in enabling the social worker to link theoretical information with day-to-day experiences in practice, to assist in the development of the worker's professional style.

Alonso (1983) summarises literature regarding the function of supervision as however still fluctuating between two ends of the spectrum: Some writers are in agreement that teaching is the primary function of supervision, while others regard the emphasis as being on emotional growth and development of the supervisee. Yet, others seem to combine the role of teaching with some form of therapeutic input in the life of the social worker being supervised. Alonso (1983) consequently states that supervision is comparable with " ... a rhombus of supervisor, therapist, patient and administration" (p 25), implying that the dynamic process of supervision can only be in equilibrium if these four forces are always taken into account. Amongst others, yet another aspect in the supervisory relationship is hereby highlighted namely that the blind eye that supervisors have turned to their own issues, need to be

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brought into the supervisory experience. Against this background, Alonso (1983) emphasises how closely paralleled the Eriksonian model of the life cycle is with that of the changing needs of the supervisor, from the development of a sense of self and identity diffusion (i e developmental needs - for approval and validation), through to the struggle in the later career to maintain self-esteem by expressing accumulated insights from years of experience, in the fight against being devalued because society regard older people with being of lesser use. The key to the enrichment of the supervision endeavour therefore seems to be found in the extent to which the supervisor's developmental issues are taken account of by the supervisor as well.

The importance of supervision as an integral part of social casework in the history and development of social work as profession, is found in its very existence despite changes in theoretical approaches to social work over the years. The therapist experienced in working within the AIDS-arena consequently has an enormous contribution to offer to clinical social workers currently confronted by the therapeutic challenges of treating patients within the HIV-range. The clinical supervisor has clinical tools and expertise coupled with insights developed in his/her own work with these patients, regarding issues like the handling of transference and countertransference, which are vital

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components within the therapeutic milieu. Some of these issues will be discussed in the rest of this section in order to highlight themes on which teaching and support as functions within supervision should focus.

Much has been written and speculated about the correlation between social workers' knowledge about HIV-infection and AIDS and the ability to therapeutically engage with the patient suffering of the disease, and stress among these workers (Pitts et al, 1990; Dow & Knox, 1991; Peterson, 1991; Schlebusch, 1991; Coyle et al, 1992; Eagle & Bedford, 1992; Cleary et al, 1992). In relation to clinical supervision of those clinicians who work with AIDS-patients, knowledge about AIDS as an illness and its psychosocial impact on the patient as well as experience in working with these patients in the HIV-range is of vital importance because training forms part of meetings between supervisor and supervisee.

Burnout in clinical workers is described as a sometimes unavoidable consequence of engagement with the AIDS-patient. The experience of multiple losses in case of the group therapist can have a similar effect (Gabriel, 1991). Oktay (1992) describes emotional exhaustion and depersonalisation as the most prevalent factors associated with burnout in clinical workers who deal with AIDS-patients. In the hospital as workplace this is characteristic due to the stressful nature of the working

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environment itself. The worker deals with a patient with an infectious disease of more or less his/her own age, who is wasting away, and who will eventually die. The fear of contagion and the countertransference feelings involved are powerful and need to be explored and dealt with by a clinical supervisor experienced in the same field, to enhance the quality of care of the patient.

Dunkel & Hatfield (1986) highlighted the fact that reported countertransference feelings and issues by social workers towards AIDS-patients include the following:

- **Fear of the unknown**

  Detachment can replace empathy if knowledge about AIDS is lacking, and depersonalisation of the person with AIDS can follow.

- **Fear of contagion**

  A panic reaction can set in from time to time out of fear of contagion.

- **Fear of dying and death**

  Fear of the patient is likely, resulting from the fantasy that death itself is transmittable as well.

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This occurs because worker' feelings about mortality is challenged within the therapeutic milieu.

- **Denial of helplessness**

A feeling of helplessness is evoked by the AIDS-patient that is difficult to own or acknowledge. Denial of this feeling may result in a belief in worker omnipotence.

- **Fear of homosexuality**

Respecting the uniqueness of the individual as social work value does not negate homophobia.

- **Overidentification**

When empathy is replaced by an inability to remain objective, overidentification results. This leads to the investment of unrealistic amounts of energy and time in the patient.

- **Anger**

Anger results from feeling helpless, fearful and guilty. In an unconscious attempt to punish the patient, irrational and explosive behaviour may follow on the part of the worker.

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- Need for professional omnipotence

  When patients reject the values of workers this need surfaces. It may happen when a patient refuses to be in the role of the patient due to being stuck in the phase of denial.

Support, coupled with the aspect of teaching, appears to be the most important function of the clinician supervising the therapist currently dealing with patients in the HIV-range. Given the strain placed on the worker concerned, there is therefore no doubt that supervision is an indispensable tool in the overall approach to successful intervention with these patients. As professional growth and development occur within the parameters of the supervisory relationship, issues belonging to the patient will become more clearly separable from those of the worker, in effect enriching the therapeutic relationship in all its facets.

3.3.10. THE ROLE AS EDUCATOR

The AIDS-crisis necessitates a concerted educational effort on the part of social workers to adequately equip future social workers to appropriately respond to the psychosocial needs of those affected by the crisis, i e the HIV- and AIDS-patient and the significant others. A

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study by Van Rooyen and Bernstein (1992) concluded that a definite need exists for "... a comprehensive contextually based education ..." of social work students in South Africa on the subject of AIDS and AIDS-related issues.

Woods (1992) and Isaacs (1992), have highlighted the importance of human sexuality as a vital but neglected component of AIDS-education due to its relevance in the therapeutic engagement with the HIV- and AIDS-patient. Its significance is grounded in the fact that the illness immediately confronts the therapist with the sexuality of the person who has contracted the virus, the mode via which it has been transmitted as well as the role of risky behaviour. In addition to the focus on the sexuality of the infected person, the therapist is also confronted with his or her own sexuality due to the aspect of countertransference. Its weight is based on the difficulties involved in the engagement process if the therapist is not yet comfortable with his or her own sexuality. Preconditions for the successful therapeutic engagement and treatment of the HIV- and AIDS-patient are a knowledge on human sexuality and its relation to the disease as well as a level of comfort in addressing the problem concerned.

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Diamond (1984) and Luria et al (1987) emphasises a definite void in the literature on the relation of human

sexuality to HIV and AIDS. It does therefore appear as though the necessary ingredients in presenting a course on human sexuality as an integral part of an AIDS-education programme need to be researched and refined further.

3.3.3.11. HUMAN SEXUALITY, AIDS AND SOCIAL WORK

Hart (1979, 6) defines human sexuality as:

> "... the expression of the physical and psychological experience of sexual desires and/or sexual usage, for physical and/or social ends."

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While writers seem to be in agreement with each other on all the necessary aspects pertaining to human sexuality as mentioned by Hart (1979), they do however seem to place the emphasis on differing aspects. Along a rather philosophical line, Weeks (1985) parallels sexuality with " ... words, images, ritual and fantasy ... " and the body (p 3), as well as "... a balance between biological source and stimuli and mental organisation of aim and object..." (p 134). Gochros (1972) however regards sexuality as the reproduction, lovemaking and the form of intimacy, closely linked to identity. Isaacs and McKendrick (1992) expands on this understanding of human sexuality by adding that the identity is a sexual one,

consequently involving the person's awareness and acceptance of it. This integration of the person's sexual identity as manifested in the consolidation of a positive self-identity, will ultimately culminate in an undistorted, meaningful expression of the self in interaction with others.

Human sexuality today has become a contested zone. Having moved beyond being a source of intense pleasure or acute anxiety, it has spiralled into becoming a moral and political battlefield since the moral panic around AIDS surfaced. As Weeks (1985) states, sanctions concerning disease do govern and encode responses to sex. Quadland et al (1987) reiterate that the original association between sexuality and life has been replaced by a devastating new association between sex and death. The consequences of the pandemic are far-reaching in nature, profoundly affecting sexual attitudes, values and behaviour of all sexually active human beings. As a tragic reality, AIDS is now being used to reaffirm social marginalisation and control. As a measure of sexual control, concern with "high-risk" sexual activities has resulted in responses by governmental and private agencies to lay down guidelines for the reduction of risk, and provide various medical and psychosocial services for those in crisis after having been diagnosed HIV-positive.

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Within social work practice, problems with sexuality seem to remain one of the most difficult aspects to deal with and is speculated to be the main reason for the reluctance with which social workers have intervened in cases of sexual problems. To the extent that social workers mirrored societal sanctioning of sexuality and projected an image of being incompetent in this field, resistance to the discussion of any sexual problems resulted on the part of the client (Gochros, 1972). The devastating impact of AIDS has however confronted social workers with their competence in the field of human sexuality to a much broader degree than ever before in the history of the profession. It challenges social workers to examine the possibility of their own sexual issues perhaps being contributory factors to this projected image. In addition to the need for courses on human sexuality in their social work training, for the generic and clinical social worker working within an agency, social sanctioning in the form of agency retribution may play a major role but for the private practitioner "unfinished business" may be a key reason. Therapeutic endeavours, involving both patient and worker, highlight unresolved issues of the clinician as well, via countertransference, as the paralleled nature of the client and worker processes unfold (Martin et al, 1989). Working with persons with AIDS therefor calls for greater self-awareness on the part of the therapist. It ultimately involves the identification of areas of

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vulnerability to countertransference issues (Dunkel and Hatfield, 1986). This has obvious implications regarding the therapist's own sexuality, his/her level of comfort in working with issues involving human sexuality, ultimately drawing attention to the therapist's acceptance of his/her own sexuality as well. The results of this study have indicated the importance of these aspects, and will be discussed in chapter four.

3.3.12. SUMMARY

This chapter dealt with the historical development of social work as a profession, and distinction which exists in terms of autonomous service delivery within private practice, in direct contrast with the services rendered in public and private agencies. The discussion focussed on generic and clinical social work engaged in, both in public agencies and in private practice. It also examined the differences which underlie practising in welfare settings, as it is contrasted with the nature of services supplied by private practitioners. Furthermore, the social worker in part-time private practice received attention, in relation to expectations of how to perform the dual role in case of being employed by a welfare agency simultaneously. In addition to these aspects, the writer also addressed the implications of being a social worker in private practice for the profession in general.

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In the final instance, the knowledge base of clinical social work was critically evaluated.

The second half of the chapter dealt with the different roles of the social worker working within the AIDS-field. The role in relation to the HIV- and AIDS-patient was explored in terms of intervention during the different stages of infection, the psychosocial crises - from fear or denial through to death, as well as concerning recurring crises. The role within the family looked at the needs within the family unit, pertaining to women with HIV and AIDS, and what the nature of intervention with children should entail. Also discussed was how the role in terms of the definition of diagnoses and treatment objectives would become a reality due to its importance in contributing to clinical intervention. The social worker's role was also explored as group therapist with HIV- and AIDS-patients, as well as in relation to teamwork with the patient and the significant others. Other indispensable roles which were under scrutiny included that in relation to issues on death, how the social worker can influence policy in terms of human rights, as well as in relation to prevention of the spread of the disease. Other roles that were focussed on included the role with regard to minorities, the important role as consultant of social workers operative in the HIVE AIDS-arena, the social worker's role as educator, and the relevance of human sexuality in

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relation to therapy with the patient in the HIV-range. The role of the educator was examined in particular in terms of the important aspect of being equipped to work with issues involving human sexuality, because HIV and AIDS relate so closely to this subject.

Given the important contribution that generic and clinical social workers in private practice have to offer in the AIDS-field, the next chapter explains the research methodology and discusses the results, linking its relevant aspects which were tested for, to its bearing on chapter 3 in terms of contextual meaning with a view to addressing its implications and recommendations for further research.

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CHAPTER FOUR

RESEARCH METHODOLOGY AND RESULTS

This section deals with the objectives of the research and the methodology applied in conducting the research, including limitations. It then presents and discusses results.

4.1. RESEARCH OBJECTIVES

The literature review has made it clear that social workers with clinical training can form a vital link between medical staff, the significant others in the life of the AIDS-patient and the patient him/herself. Given the psychosocial stressors which the patient is exposed to, questions emerged around whether social workers in private practice are equipped to treat people with AIDS or who are living with HIV infection, and the extent to which a lack of basic knowledge on the issue causes bias toward these clients. The research, which was limited to private practitioners in the Western Cape, had the following objectives:

a) To determine whether social workers in private practice feel adequately equipped to deal with the issues of HIV, AIDS and human sexuality.

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b) To assess whether there is any correlation between homophobia i.e. the irrational fear of homosexuals - and attitudes towards HIV- and AIDS-patients.

c) To establish the extent to which treatment of the HIV or AIDS-patient is influenced by possible discrimination, feelings of bias as well as a lack of specialised knowledge of AIDS.

d) To establish whether there is any correlation between attitudes to terminally ill patients in general and that to HIV- and AIDS-patients so that the degree to which the former contributes to the latter can be gauged.

e) To establish whether there is any correlation between attitudes to HIV- and AIDS-patients and that to sexuality in general.

f) To assess whether there is a significant difference between attitudes of male social workers and that of females.

The background to each of the above objectives is discussed in greater detail later in this chapter (See section 4.12).

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4.2 HYPOTHESES TESTED

In the light of the above objectives, the following hypotheses were tested:

- H_{01} : There is no significant correlation between training and/or knowledge regarding HIV-infection and AIDS and attitudes pertaining to the treatment of HIV- and AIDS-patients.

Expressed in mathematical terms:

- $H_{01} : \rho_{ka} = 0$

where ρ_{ka} is the correlation coefficient between knowledge on the subject of AIDS and attitudes with respect to HIV/AIDS-patients.

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- H_{02} : There is no correlation between homophobia and attitudes regarding the treatment of HIV- and AIDS patients.

or,

- $H_{02} : \rho_{ha} = 0$

where ρ_{ha} is the correlation coefficient between social workers' attitudes to homosexuals and that to treating HIV- or AIDS-patients.

- H_{03} : There is no correlation between the social workers' attitudes toward sexuality in general and attitudes regarding the treatment of HIV- and AIDS-patients.

or,

- $H_{03} : \rho_{sa} = 0$

where ρ_{sa} is the correlation coefficient between the social workers' attitudes to sexuality and that to treating HIV and AIDS-patients.

- H_{04} : There is no significant difference between the attitudes of males and that of females within the population with regard to attitudes to HIV- and AIDS-patients.

or,

- $H_{04} : \mu_{ma} = \mu_{fa}$

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where μ_{ma} is the average score of males on attitudes to HIV- and AIDS-patients, and μ_{fa} that of females on attitudes to HIV- and AIDS-patients.

The data allowed for similar hypotheses to be tested, comparing male and female attitudes with regard to sexuality, homosexuality and terminally ill patients.

4.3. SELECTION OF SUBJECTS

This study concerns itself with the measurement of attitudes of social workers in private practice in the Western Cape toward HIV- and AIDS-patients. It attempts to draw inferences concerning parameters of this particular population. From the research objectives it is clear that a finite population with a limited size is involved. The objective contains a very clear definition of the population. An attempt was therefore made to sample the entire population. A list of all potential candidates could be obtained from the Association of Social Workers in Private Practice. All persons on this list were approached to participate in the study - a total of 29 subjects.

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4.4. METHODOLOGY OF TESTING THE HYPOTHESES

Although a statistical package was used to test the hypotheses, the methodology involved is described below.

4.4.1. TESTING THE HYPOTHESES CONCERNING SAMPLE MEANS

This procedure was used in testing the hypotheses on mean attitude scores for male and female workers of the population respectively.

The procedure for testing a hypothesis concerning the means of two populations can be summarised as follows:

Assume that the populations are approximately normally distributed with equal variances. Let μ_1 and μ_2 represent the population means. Then:

a) $H_0: \mu_1 = \mu_2$

b) $H_1 : \mu_1 > \mu_2$

c) Choose a level of significance

d) Determine the critical region with:

$$T = (\bar{X}_1 - \bar{X}_2) / (S_p \sqrt{1/n1 + 1/n2})$$

$\bar{X}_1$ = Mean of sample from population 1

$\bar{X}_2$ = Mean of sample from population 2

S_p = An estimation of the standard deviation within each population

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n_1 = Size of sample from population 1

n_2 = Size of sample from population 2

with v degrees of freedom for a sample of size smaller than 30, $v = n_1 + n_2 - 2$

e) Compute the value of the t statistic from random samples of sizes n_1 and n_2 .

f) Conclusion: Reject H_0 if t falls in the critical region, otherwise accept the null hypothesis.

4.4.2. TESTING THE HYPOTHESES CONCERNING CORRELATIONS

The measure of a linear relationship between two random variables X and Y is estimated by the sample correlation coefficient r (the Pearson product-moment correlation coefficient) where:

$$r = b\sqrt{S_{xx}/S_{yy}} = S_{xy}/\sqrt{(S_{xx}\ S_{yy})}$$

where E(b) = β , β a parameter which represents the x coefficient in the linear regression equation:

$$\mu_{Y|x} = \alpha + \beta x$$

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$$S_{xx} = \sum_i (x_i - \bar{x})^2$$

$$S_{yy} = \sum_i (y_i - \bar{y})^2$$

$$S_{xy} = \sum_i (x_i - \bar{x})(y_i - \bar{y})$$

The observations $\{(x_i ; y_i); i = 1,2,\ldots,n\}$ are from a joint density function $f(x , y)$. The test procedure is summarised below (See Walpole and Myers, 1978:306-307).

a) Assume the joint density function of X and Y has a bivariate normal distribution.

b) $H_0 : \rho = 0$ (No correlation)

c) $H_1 : \rho \neq 0$

d) Choose a level of significance

e) Compute $z = \sqrt{n-3}/2 \ \ln((1+r)(1-\rho_0)/(1-r)(1+\rho_0))$, and compare with the critical points of the standard normal distribution.

f) Conclusion: Reject H_0 if the statistic has a value in the critical region, otherwise accept H_0 .

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4.5. QUESTIONNAIRE

A detailed questionnaire which would take approximately 40 minutes to administer was designed for the purposes of the research and mailed to all practitioners listed. An entire population was therefore surveyed. Questionnaires were anonymous, treated as confidential, and individually scored. A copy is included in the appendices. In essence, the survey instrument had to measure the following:

(1) The social worker's knowledge on the subject of HIV and AIDS.

(2) His or her experience in treating HIV- and AIDS patients.

(3) The nature of attitudes with respect to HIV- and AIDS-patients.

(4) The nature of attitudes with respect to homo- and heterosexual clients.

(5) The nature of attitudes with respect to sexuality in general.

(6) The nature of attitudes with respect to the terminally ill.

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The knowledge of respondents was measured by the number of correct responses to questions which test their knowledge on the subject of AIDS or HIV infection. Their attitudes were assessed on a 4-point Likert-scale (1=strongly disagree to 4=strongly agree). Homophobia, as defined in section 4.1., was measured by using a 4-point Likert-scale in questions designed to test for this characteristic.

The accurate measurement of people's attitudes is not an easy task, and is in itself a vast subject. One such problem of investigating attitudes for instance is that it is extremely difficult to avoid putting words into the subject's mouth. Prior to the main study, the questionnaire was therefore piloted among a few social workers in private settings at various agencies so that shortcomings in the preliminary design could be highlighted. In the pilot study, informants were asked to indicate incomprehension and ambiguities. A single question was added to the questionnaire after the pilot study. The responses of subjects in this study were not taken into account in the final data analysis. The final questionnaire comprised 41 items.

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4.6. INSTRUMENT VALIDITY AND RELIABILITY

The extent to which a questionnaire is doing what it is intended to do and the degree to which it is free from errors is termed its **validity** and **reliability** respectively. It is essential that the questionnaire's validity and reliability be assessed, as these two measures provide an indication of the integrity of sample data collected and hence the research process ad results.

4.6.1. INSTRUMENT VALIDITY

Bostwick and Kyte's definition of validity in Grinnell (1985) involves two aspects. The first, that the questionnaire actually measures the relevant concepts - in this case attitudes and knowledge. The second, that such concepts are measured accurately. In order to establish whether the apparatus employed in this study does in fact measure the variables in question, it is necessary to explore its content validity. Content validation is a process which concerns itself with instrument content representativeness (Bostwick and Kyte in Grinnell, 1985).

The instrument measures knowledge about AIDS, attitudes toward AIDS/HIV patients, attitudes to homosexuality attitudes to sexuality in general and attitudes in treating terminally ill clients. It was adapted from a

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questionnaire devised by Steinfeld and Weinberg (1991) for a study on attitudes of senior physiotherapy students in the Western Cape towards HIV/AIDS patients. The instrument for this study differs from that by Steinfeld and Weinberg in that it focuses on an entirely different population, and it also measures attitudes to sexuality. In addition, it attempts to measure the extent to which gender and experience play a role in attitudes. The objectives of this study also differs radically from the one on physiotherapists so that a direct comparison of results cannot be made. The degree to which the instrument measures attitudes to HIV/AIDS and knowledge on the subject compares favorably with similar such instruments devised by Samuels and Boyle (1989) and McManus and Morton (1986). The extent to which the questionnaire covers the measurement of attitudes to sexuality and that to terminally ill patients is not as elaborate in terms of the number of items covered, but it is felt that this does not undermine the validity of the instrument in respect of these aspects of the study.

4.6.2. INSTRUMENT RELIABILITY

Instrument reliability indicates the degree to which individual differences in scores are attributable to true differences in the characteristic being measured and to errors of measurement (Bostwick and Kyte in Grinnell, 1985). Various methods are used to assess the

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reliability of a questionnaire. The degree of consistency with which a respondent deals with an aspect which the questionnaire attempts to measure, can give an indication of the accuracy with which the instrument measures that particular characteristic. The variance in attitudinal scores of the pilot study subjects, derived from responses to individual items on the questionnaire, was calculated. The variances were found to be less than one for scores with relation to attitudes to HIV/AIDS-patients, that to sexuality, that to homosexuality and that to clients who are terminally ill in the case of all the subjects.

4.7. LIMITATIONS OF THE STUDY

It is necessary to bear the following in mind:

a) Sample findings are not representative of the entire social work private practice community in South Africa, the clinical social work community or of the social worker community in general so that it would be wrong to extrapolate conclusions of this study to these populations. The study focuses on social workers in private practice in the Western Cape and findings therefore only relate to the relevant statistics of this particular population. In addition, the terms direct service practice, clinical social work and private practice are used

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interchangeably. This procedure does not take cognisance of the fact that not all private practitioners are clinically trained.

b) No attempt was made to undertake a detailed analysis of the variances in responses - i.e. to what extent differences in age, or university can explain variances in attitude and knowledge.

c) By using parametric procedures it is implicitly assumed that the relevant random variables are normally distributed or that it cannot be shown that this is not the case.

d) The means and modes of intervention of generic and clinical social workers can differ radically. No attempt has however been made to make a distinction between the attitudes of these to subgroups in the sample or to test for differences. The results are dealt with on a pooled basis and should be interpreted as such.

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4.8. DATA ANALYSIS

Data extracted from responses of the questionnaires were recorded onto a Lotus 123 (Lotus Development Corporation) spreadsheet. Data were then transferred to STATGRAPHICS (Statistical Graphics Corp.) files for further analysis.

STATGRAPHICS is a statistical analysis package for use on a personal computer. It has the capability of generating a matrix of Pearson product-moment correlations for a set of variables, a facility which came in useful for this analysis.

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RESEARCH RESULTS

This section presents results of the investigation. The approach will be to first present and describe results after which these are interpreted.

4.9. DEMOGRAPHICS OF RESPONDENTS

Table 5 exhibits a breakdown of demographic information on the sample. A total of 18 questionnaires was administered representing a return rate of 62%, and the analysis in this study is based on these responses.

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TABLE 5 : DEMOGRAPHIC INFORMATION

CATEGORY	NUMBER	PERCENTAGE
GENDER		
Male	3	16.7%
Female	15	83.3%
RELIGIOUS AFFILIATION		
Jewish	3	16.7%
Anglican	6	33.3%
Roman Catholic	2	11.1%
Dutch Reformed	1	5.6%
None	6	33.3%
INSTITUTION WHERE QUALIFICATION WAS OBTAINED		
University of Cape Town	9	50.0%
University of Stellenbosch	5	27.8%

TABLE 5 (Continued)

University of South Africa	1	5.6%
Wits	3	16.7%
University of Pretoria	2	11.1%
HIGHEST LEVEL OF QUALIFICATION		
B A (S/W) III	2	11.1%
B A (HON.) S/W	5	27.8%
M.CLIN.S/W	10	55.6%
Ph.D	1	5.6%

(Note that approximately 61 % of the respondents are clinical social workers while 39 % are involved in generic social work in private practice.)

MEMBER OF A PROFESSIONAL BODY		
Family and Marital Therapy Society	1	5.6%
Institute of Psychotherapy	2	11.1%
Institute of Family Therapy	1	5.6%
Institute of Group Therapy	1	5.6%

OTHER QUALIFICATIONS/EXPERIENCE	
Divorce Mediation	1
Nursing	1
Business Management	1
Bereavement Counselling	1
Typing	1

SUBURBS OF RESIDENCE

Bergvliet
Claremont
Constantia
Groenvlei (Paarl)
Kenilworth
Newlands
Observatory
Rondebosch
Woodstock
Wynberg

AGES range from 32 to 64.

YEAR OF ATTAINMENT of qualification range from 1947 to 1990.

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4.10. TESTING THE HYPOTHESES ON CORRELATIONS

4.10.1. RESULTS

TABLE 6: Correlational Findings

	KNOWLEDGE	AIDS	HOMO	SEX	TERM	EXPOSURE	PRACTICE
KNOWLEDGE	1.0000	.0506	-.1751	-.0494	-.0661	.2271	.3122
	(18)	(18)	(18)	(18)	(18)	(18)	(18)
	.0000	1.0000	.8979	1.0000	1.0000	.5672	.1024
AIDS	.0506	1.0000	.2026	.0820	.1121	.3314	.1880
	(18)	(18)	(18)	(18)	(18)	(18)	(18)
	1.0000	.0000	.7455	1.0000	.9985	.0608	.8352
HOMO	-.1751	.2026	1.0000	.6226	.3478	.2381	.0938
	(18)	(18)	(18)	(18)	(18)	(18)	(18)
	.8979	.7455	.0000	.0000	.0377	.4849	.9998
SEX	-.0494	.0820	.6226	1.0000	.0709	.2901	.0259
	(18)	(18)	(18)	(18)	(18)	(18)	(18)
	1.0000	1.0000	.0000	.0000	1.0000	.1767	1.000
TERM	-.0661	.1121	.3478	.0709	1.0000	.2172	.0848
	(18)	(18)	(18)	(18)	(18)	(18)	(18)
	1.0000	.9985	.0377	1.0000	.0000	.6419	1.000
EXPERIENCE	.2271	.3314	.2381	.2901	.2172	1.0000	.1320
	(18)	(18)	(18)	(18)	(18)	(18)	(18)
	.5672	.0608	.4849	.1767	.6419	.0000	.9912
PRACTICE	.3122	.1880	.0938	.0259	.0848	.1320	1.000
	(18)	(18)	(18)	(18)	(18)	(18)	(18)
	.1024	.8352	.9998	1.0000	1.0000	.9912	.0000

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Key to variables:

AIDS - Attitudes to AIDS-patients

Knowledge - Knowledge on the subject of AIDS

Homo - Attitudes to homosexuality

Sex - Attitudes to sexuality in general

Term - Attitudes to terminally ill patients

Experience - Degree of exposure to and experience with AIDS-patients

Practice - Years in direct and private practice

Table 6 depicts a correlation matrix which shows the sample correlation coefficients, the sample size and the significance level at which the null hypotheses can be rejected. The results indicate the following:

a) There is no significant correlation between knowledge about AIDS and attitudes to AIDS for the population under study. The null hypotheses is accepted at the 10% level.

b) The results show no significant correlation between attitudes to homosexuals and that to AIDS. The null hypotheses is accepted at the 10% level.

c) The results show no significant correlation between attitudes to terminally ill patients and that to AIDS patients. The null hypotheses is accepted at the 10% level.

d) There is a positive correlation between the degree of exposure to AIDS and experience with HIV/AIDS-patients, and attitudes to AIDS. The null hypotheses is rejected at the 6% level.

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e) There is no significant correlation between attitudes to sexuality in general and that to AIDS. The null hypotheses is accepted at the 10% level.

In addition to the above, the following results are of interest:

a) The results show a very strong correlation between attitudes to sexuality and that to homosexuality. The null hypotheses is rejected at the 1% level.

b) Similarly there is a strong positive correlation between attitudes to homosexuality and that to terminally ill patients. The null hypotheses is rejected at the 4% level.

c) The correlation between exposure to AIDS and attitudes to sexuality tend toward significance, but the chances of committing the type I error (erroneously rejecting the null hypotheses) is large (17.7%).

d) There is no significant correlation between attitudes to terminally ill patients and exposure to AIDS patients. The null hypotheses is accepted at the 10% level.

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e) There is no significant correlation between knowledge and exposure to AIDS patients. The null hypotheses is accepted at the 10% level.

f) There is no significant correlation between years of experience in the field and attitudes to AIDS patients. The null hypotheses is accepted at the 10% level.

g) There is a significant correlation between knowledge and experience in the field. The null hypotheses is rejected at the 10% level.

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The results therefore indicate significantly positive correlations between attitudes to AIDS/HIV patients on the one hand and exposure to AIDS/HIV cases and attitudes to sexuality on the other. The results also indicate significantly positive correlations between attitudes to homosexuals on the one side and attitudes to sexuality and terminally ill patients on the other. Finally, results point to a significantly positive correlation between knowledge on the subject of AIDS and experience in the field.

These outcomes will be discussed in detail later on in this chapter.

4.11. TESTING THE HYPOTHESES ON GENDER AND DIFFERENCES IN ATTITUDES

4.11.1. RESULTS

TABLE 7:Test for significant differences in attitudes regarding AIDS

		Sample 1	Sample 2	Pooled
Sample Statistics:	Number of Obs.	15	3	18
	Average	55.7333	60.3333	56.5
	Variance	59.2095	272.333	85.85
	Std. Deviation	7.69477	16.5025	9.26553
	Median	57	60	57

Conf. Interval For Diff. in Means:		90 Percent	
(Equal Vars.)	Sample 1 - Sample 2	-14.8334 5.63336	16 D.F.
(Unequal Vars.)	Sample 1 - Sample 2	-31.507 22.307	2.2 D.F.

Hypothesis Test for H0: Diff = 0	Computed t statistic = -0.784978
vs Alt: LT	Sig. Level = 0.221967
at Alpha = 0.1	so do not reject H0.

Table 7 shows that the attitudes of males and females within the population with respect to HIV/AIDS-patients are not significantly different from one another (The null hypothesis is accepted at the 10% level). Note that the average score for attitudes regarding AIDS for men is higher than that for women. The difference in the two averages was however not large enough for the null hypotheses to be rejected. There is conflicting evidence in the literature regarding attitudinal differences between male and female workers. Pitts et al (1990) found that men had a more positive attitude towards HIV and AIDS than did women, while Larsen et al (1991) showed that women were more positive in their attitudes towards AIDS-patients than men.

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The large disparity in sample size is implicitly taken into account in the test for significant differences. The large difference in sample size makes it more difficult to have the null hypotheses of no attitudinal differences rejected.

TABLE 8:Test for significant difference in attitudes regarding sexuality

		Sample 1	C:MALEAT.SEX	Pooled
Sample Statistics:	Number of Obs.	15	3	18
	Average	11.3333	14	11.7778
	Variance	3.38095	0	2.95833
	Std. Deviation	1.83874	0	1.71998
	Median	11	14	12

Conf. Interval For Diff. in Means:		95 Percent	
(Equal Vars.)	Sample 1 - Sample 2	-4.9733 -0.360038	16 D.F.
(Unequal Vars.)	Sample 1 - Sample 2	-3.68518 -1.64815	14.0 D.F.

Hypothesis Test for H0: Diff = 0	Computed t statistic = -2.45141
vs Alt: LT	Sig. Level = 0.0130496
at Alpha = 0.05	so reject H0.

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Table 8 indicates that the attitudes of males and females within the population with respect to sexuality in general are significantly different from one another (The null hypothesis is rejected at the 5% level). All male respondents are homosexuals who have accepted their sexuality and can therefore relate easier to sexual matters.

TABLE 9:Test for significant differences in attitudes regarding homosexuality

Sample Statistics:		Sample 1	Sample 2	Pooled
	Number of Obs.	15	3	18
	Average	9.73333	12	10.1111
	Variance	2.6381	0	2.30833
	Std. Deviation	1.62422	0	1.51932
	Median	10	12	10

Conf. Interval For Diff. in Means: 95 Percent
(Equal Vars.) Sample 1 - Sample 2 -4.30419 -0.229139 16 D.F.
(Unequal Vars.) Sample 1 - Sample 2 -3.16636 -1.36698 14.0 D.F.

Hypothesis Test for H0: Diff = 0 Computed t statistic = -2.35889
vs Alt: LT Sig. Level = 0.0156892
at Alpha = 0.05 so reject H0.

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This table shows that male social workers within the population have a significantly more positive attitude to homosexuality (The null hypothesis is rejected at the 5% level). It must be borne in mind that the larger portion of male respondents admitted to being homosexual. It therefore follows that male respondents will be in a better position to identify and therapeutically engage with homosexuals patients due to their in-depth understanding of the subculture of the patient. This finding can however not necessarily be extrapolated to the larger population of social workers. A study by Larsen et al (1991) found the opposite in that women were more tolerant of homosexuals. Gender differences in attitudes to homosexuality therefore appear to clearly vary.

TABLE 10:Test for significant differences in attitudes towards the terminally ill

		Sample 1	Sample 2	Pooled
Sample Statistics:	Number of Obs.	15	3	18
	Average	6.6	6.66667	6.61111
	Variance	1.82857	5.33333	2.26667
	Std. Deviation	1.35225	2.3094	1.50555
	Median	7	8	7

Conf. Interval For Diff. in Means:		95 Percent	
(Equal Vars.)	Sample 1 - Sample 2	-2.08572 1.95239	16 D.F.
(Unequal Vars.)	Sample 1 - Sample 2	-5.34719 5.21385	2.3 D.F.

Hypothesis Test for H0: Diff = 0	Computed t statistic = -0.070014
vs Alt: LT	Sig. Level = 0.472525
at Alpha = 0.05	so do not reject H0.

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Table 10 indicates that attitudes of males and females within the population with respect to terminally ill patients are not significantly different from one another (The null hypothesis is accepted at the 5% level). Training may serve as determining factor in this study because all the respondents were positive in their attitudes towards the treatment of the terminally ill.

4.12. DISCUSSION OF RESULTS

4.12.1. KNOWLEDGE ABOUT AIDS

Respondents displayed a fairly good factual knowledge of AIDS. The scores range from 67% correct to 100% correct. Each respondent knew that AIDS involves the immune system. Some 89% responded correctly about AIDS being a terminal illness, while 83% answered correctly that having contracted the HIV-virus does not mean that

one has AIDS. However, while 83% were informed about the fact that AIDS is primarily a sexually transmitted disease, only 72% were correct about a person being equally at risk through one unprotected sexual contact. It is indicative of a difference between being well informed about AIDS, and being familiar with modes of transmission of the HIV-virus and being up to date with current literature. Some 72% of respondents answered correctly that the sweat of an AIDS-patient is not contagious, while 67% expressed certainty about the fact that the shaking of the hand of the infected person excludes the risk of becoming infected. This lack of certainty among the other respondents about whether the sweat of the infected person is contagious, is paralleled by a possible fear of contagion, or being uninformed.

4.12.2. KNOWLEDGE ABOUT AIDS AND ATTITUDES TOWARDS AIDS-PATIENTS

The data on the attitudinal dimensions present a complex picture. Responses on the Likert-scale were interpreted as followed: strongly agree and moderately agree = agree, and; strongly disagree and moderately disagree = disagree.

The study has shown no significant correlation between knowledge about AIDS and attitudes towards HIV/AIDS-patients. This result indicates that relatively good

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knowledge on the subject of AIDS does not necessarily imply a positive attitude towards an HIV/AIDS-patient.

For example, respondents with a high score in the knowledge section did not necessarily register a strong positive attitude towards an HIV/AIDS-patient. Similarly, respondents with a relatively low score on the subject of AIDS did not always register a low attitudinal score with regard to an HIV/AIDS-patient (Mr Johnson in referral letter, see Appendix for details).

This finding confirms the results of McManus and Morton (1986), although an entirely different population was studied. As in the above mentioned British study where no correlation was found between knowledge about AIDS and attitudes to AIDS, the informed view of the respondents in this current study is counteracted by findings in relation to some other dimensions assessed. For example, attitudes of the respondents were more influenced by exposure to and experience in the treatment of HIV/AIDS-patients (see results discussed later). Fear of contagion was not counteracted by knowledge on the subject. According to McManus and Morton (1986) this correlational finding is not uncommon in social psychology.

While the present research did not find a significant correlation between knowledge about AIDS and attitudes to AIDS, Eagle and Bedford (1992) and Schlebusch et al

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chances of committing a type I error is 74.6%). This result is counterintuitive because AIDS has had a long association with homosexuals, homosexuals have been regarded as a high risk group, and other studies done on other population groups show a strong positive correlation between attitudes towards homosexuals and that to AIDS (Eagle and Bedford, 1992; McManus and Morton, 1986).

However, it can be speculated that prejudice may not be operative at a conscious level due to the profession's value base which calls for the expression of a non-judgmental attitude. In addition to this speculation, three respondents were ambivalent about responding to questions tapping attitudes towards homosexuals at all, which may have resulted from countertansference reactions that were contrary with a non-judgmental attitude. There may also be an increasing awareness of the fact that AIDS is becoming more of a heterosexual problem, so that the association between AIDS and homosexuals has become vague. The abovementioned studies show positive correlations as resulting from negative attitudes to homosexuals correlating with negative attitudes to HIV/AIDS-patients (see Eagle and Bedford, 1992). In strong contrast, this research has brought to light that respondents hold rather positive or unbiased attitudes towards homosexuals. While positive responses account

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for 100% of respondents in question 31, 61% of respondents answered positively to question 34.

4.12.4. ATTITUDES TO TERMINALLY ILL PATIENTS AND THAT TO HIV/AIDS-PATIENTS.

The research results indicate no significant correlation between attitudes to terminally ill patients and that to AIDS-patients. Being comfortable in working with terminally ill patients does not necessarily indicate the same degree of comfort in treating an AIDS-patient. This may be indicative of the fact that exposure to and the treatment of the terminally ill (e g cancer patients) is not being regarded as the same as exposure to and treatment of an AIDS-patient due to the difference in the nature of the disease. In this study, fear of contagion has been shown to not decrease or become negated with an increase in knowledge about AIDS. One can also not make the statement that fear of working with AIDS-patients results from fear of working with terminally ill patients in general.

4.12.5. EXPOSURE TO AND EXPERIENCE WITH AIDS-PATIENTS, AND ATTITUDES TO AIDS.

This research has indicated that a positive correlation does exist between the degree of exposure to and experience in treatment of AIDS-patients, and attitudes

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to AIDS. This finding correlates positively with similar studies (Samuels & Boyle, 1989; Pitts et al, 1990). The sample of the population in this study showed relatively little experience with or exposure to AIDS-patients. Only 6% had had a patient referred with AIDS, while only 6% of respondents ever rendered clinical social work services to patients with AIDS.

Exposure to training courses on AIDS and the treatment of AIDS-patients influenced attitudes to AIDS-patients in a positive manner. It is evident from this study that exposure to AIDS-patients enabled the respondent to come to terms with the fear of contagion, and move beyond that point to treatment of the patient with a positive attitude. This finding corresponds closely with the finding of Dow et al (1991) that professionals who had experience in working with HIV-positive and AIDS-patients were more knowledgeable about the disease, had less discomfort, and were less likely to want to avoid these patients, indicating less fear and more positive countertransference feelings.

Exposure to and experience with AIDS-patients correlates positively but poorly with knowledge, i e not significantly. This study has shown that knowledge without any exposure to an AIDS-patient does not necessarily lead to a positive attitude towards an AIDS-patient. However, knowledge about AIDS is a necessary

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ingredient for the creation of a climate of exposure and therapeutic engagement with such a patient.

This correlation is also indicative of the fact that experience with and exposure to an AIDS-patient leads to a reduction in fear and bias.

4.12.6. ATTITUDES TO SEXUALITY IN GENERAL, AND THAT TO AIDS-PATIENTS.

TABLE 12: ATTITUDES TO SEXUALITY IN GENERAL, AND THAT TO AIDS-PATIENTS

STATEMENT	YES	NO	UNCERTAIN
10. Should social workers in private practice administer safe sex information to their clients?	94%	6%	0%
11. Would you feel comfortable in using a condom and sexual devices eg. plastic penis/vagina to demonstrate safe sex to clients?	83%	0%	11%

STATEMENT	SA	MA	MD	SD
34. I would be comfortable in exploring intimate sexual practices with a homosexual client.	33%	28%	22%	6%
39. I am comfortable in dealing with sexual matters with my clients.	72%	17%	6%	0%

The balance of respondents had no response to statements 11 and 39.

This study has not shown any significant correlation between attitudes to sexuality in general, and that to

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AIDS- patients. This finding is in contradiction with a study by Schlebusch et al (1991), who found that the attitudes of other health care professionals (no social worker was involved; 82% of the sample was white) to AIDS-patients correlated positively with both attitudes to the sexuality of Blacks and to that of homosexuals. A group of social workers studied by Gillman (1991) brought forward the opposite finding, which is in correspondence with the results of this study.

Respondents scored high on questions examining attitudes to sexuality, which also indicated their level of comfort with their own sexuality.

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4.12.7. TRAINING

Two questions were included in the questionnaire to ascertain the degree to which respondents felt adequately trained in the field of AIDS to enable them to therapeutically engage with an AIDS-patient. Another question which focuses on any further training in the field of AIDS by respondents, was included. The questionnaire also tried to establish the degree to which respondents felt able to use prior experience in the field of AIDS. A question dealing with feeling adequately trained to focus on issues pertaining to human sexuality was also included, to be compared with attitudinal questions regarding human sexuality.

4.12.7.1. TRAINING WITH REGARD TO HIV-INFECTION AND AIDS

The following responses emerged:

TABLE 13 : VIEWS ON TRAINING WITH REGARD TO HIV-INFECTION AND AIDS

STATEMENT	SA	MA	MD	SD
33. My university training provided me with adequate information about HIV-infection and AIDS and treating these patients.	0%	11%	0%	83%
37. More emphasis on AIDS education and treatment strategies should be incorporated into the social work syllabus.	50%	28%	6%	0%

The balance of respondents had no response to statements 33 and 37.

Responses represented an outcry for more AIDS education (78%), and indicated a strong feeling of being inadequately trained and equipped to enable respondents to engage therapeutically with HIV-infected persons and AIDS-patients (83%). Despite the fact that respondents may not have had the relevant training in their courses, the majority of them have however sought to upgrade their training, through the attendance of training sessions offered at ATTIC. Respondents' lack of involvement in the treatment of AIDS-patients (only 6% rendered clinical social work services or participated in the treatment of AIDS-patients in this study), seem to be linked to their discomfort in engaging with these patients due to lack of training. In essence they are

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acknowledging that their perception of other terminally ill patients differs from that of AIDS-patients.

Question four posed the question as to whether respondents have recently attended training sessions pertaining to HIV- and AIDS- issues. It was interesting to see responses ranging from eleven respondents not having attended any sessions, to six having attended either a one day lecture on AIDS or a workshop presented by the AIDS Training and Information Center (ATTIC) in Cape Town. One respondent had attended AIDS-conferences in the USA, UK, and Holland, which included specialised training in safe-sex education and psychotherapy. In retrospect, only 39% of the respondents have attended training sessions of some nature, while 61 % were not aware of such training sessions being offered. One could perhaps interpret this finding as an indication of a lack of interest in becoming better equipped to become involved in the AIDS-arena, or the poor marketing of such courses.

In question 9 the respondents were asked to specify some areas in which they would feel able to contribute towards the treatment of the AIDS-patient and/or significant others. A pattern of feeling ill-equipped and unable to marry experience in other fields with the field of AIDS, emerged in the lack of responses of 28% of the respondents. The balance (72%) expressed a willingness

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to engage in individual therapy with the AIDS-patient, bereavement counselling, survivor counselling, family therapy regarding terminal care, group therapy, therapy with gay patients by an experienced gay therapist, preventative education at schools, couples' therapy with sexually dysfunctional couples, psychotherapy and pre- and post-test counselling.

This response indicated the vast amount of experience that the respondents do have. No significant correlation was however found between the age and years of experience in the field, and attitudes to AIDS-patients. This result is indicative of the fact that this wealth of experience in other fields of clinical social work may not necessarily be beneficial for engagement with AIDS-patients without a close examination of countertransference reactions to these patients as well as knowledge about the disease and its modes of transmission.

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4.12.7.2. TRAINING WITH REGARD TO SEXUALITY

Responses to the question which deals with the adequacy of training on matters pertaining to human sexuality in therapy, indicated an uncertainty about being adequately equipped. While 11% strongly agreed with the statement in question 35, 50% were uncertain about the statement by only expression a mild agreement with the truth thereof.

The reaction to this statement highlights the discrepancy in their expression of a very positive attitude and being comfortable with addressing issues pertaining to sexuality in their practice, and their strong tendency to not feel adequately equipped by their training to deal with such issues.

4.12.8. GENDER AND DIFFERENCES IN ATTITUDES TOWARDS AIDS-PATIENTS.

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a) The study did not find any significant difference between the attitudes of males and females regarding AIDS-patients. Both males and females held similar attitudes towards AIDS-patients. This result differs with the outcome of an international attitudinal comparison on the same subject by Larsen et al (1991), with another population as sample. It indicated an international difference in attitudes towards AIDS-patients with women having more positive attitudes. The reason for the difference in the outcome of this study is most probably the aspect of training and the value orientation of a non-judgmental attitude which forms part of the repertoire of the respondents of this study.

b) The result on the attitudes of males and females with regard to sexuality in general, did not

indicate any significant difference from one another. Both males and females were equally willing to address issues regarding sexuality with their patients.

c) The study indicated that males within the population have a significantly more positive attitude towards homosexuals than do women. This finding differs with a study by Larsen et al (1980), who found that women were more tolerant of homosexuals compared with men.

d) The study found that attitudes of males and females with respect to terminally ill patients are not significantly different from one another. This finding may be attributed to the fact of training and a shared value base of respondents, or to a shared feeling of being either comfortable with, or uncomfortable with such patients without gender affecting attitude as such.

4.12.9. FACILITIES FOR THE COMPREHENSIVE TREATMENT OF AIDS-PATIENTS.

Question five was included to ascertain the knowledge of respondents with regard to adequate facilities in the Western Cape for the comprehensive treatment of people

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with AIDS. Respondents were also allowed to explain the reason for any particular response to the question.

While 67% responded that there are not adequate facilities for this purpose, 33% were rather uncertain about the current situation. A plea was made for more facilities for paediatrics, townships, hospital care and community centers for the terminally ill patients. Of significance about this high percentage of respondents regarding facilities as being inadequate, is the fact that the majority of them were not substantiating their claims by suggesting specific facilities. It could be an indication that there is a large amount of ignorance about the nature and locality of such facilities.

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4.12.10. THE ROLE OF THE CLINICAL SOCIAL WORKER IN THE AIDS-ARENA.

Three questions were posed to respondents to establish their views regarding the profession's role and responsibility in the AIDS-arena. Respondents indicated an unwillingness to regard themselves as responsible for tracing the partners of persons who are HIV-positive (56% answered NO). However, 94% strongly agreed that AIDS-patients are likely to be referred for social work therapy in future, while 89% disagreed with the statement that social workers do not have any role to play in the management of AIDS-patients. There is therefore a strong

indication that respondents are acknowledging their role within the AIDS-arena.

It is thus apparent that respondents are aware of their own important role within the AIDS-arena, but the attitudes indicate stumbling blocks on this road of rendering services. Issues such as fear of contagion, etc. need to be addressed to enable them to become effective therapists in the fight against AIDS.

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4.13. SUMMARY

This chapter explained the method by which the research were conducted. In attempting to achieve this goal, the research objectives were explained in terms of the hypotheses which needed to be tested, and the selection procedure of the subjects of the study. Furthermore, a statistical explanation was provided for both the testing of hypotheses concerning sample means and the testing concerning correlations. As instrument of the research, the nature and design of the questionnaire was focussed on at large. Linked in importance to the instrument of the research, its validity and reliability was explored in relation to relevant aspects in this regard. Some limitations of the research were then discussed. Concluding the first half of this chapter, the method of data analysis was explored in terms of statistical measures.

The research results were then presented. The discussion of the results and its comparison with outcomes of other studies of a similar nature, explored respondents' reactions in relation to their knowledge about AIDS and if and/or how it affected their attitudes towards AIDS-patients. Results did not indicate any significant correlation among attitudes to AIDS-patients, knowledge on the subject of AIDS, attitudes to homosexuals, attitudes to terminally ill and that to sexuality. The study however indicated a positive correlation between the amount of experience in working with AIDS-patients and exposure to these given patients, and attitudes to AIDS-patients. Furthermore, it was found that there was no significant difference between attitudes of males and females with regard to HIV/AIDS-patients.

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Against the background of these research results, the following chapter focuses on the implications that it holds for social work practice, and additionally explores areas for future research in an attempt to enable the social work profession to render the best service possible to HIV-infected and AIDS-patients and their significant others.

CHAPTER 5

IMPLICATIONS FOR SOCIAL WORK PRACTICE WITH SPECIAL REFERENCE TO SOCIAL WORKERS IN PRIVATE PRACTICE SETTINGS.

5.1. TRANSFERENCE AND COUNTERTRANSFERENCE

The study has highlighted important countertransference aspects which are of relevance for clinical social workers, who mainly engage with the HIV- and/or AIDS-patient on the preconscious, subconscious and unconscious level. Each of these aspects have definitive implications for consultation, education and training of clinical social workers. These implications are dealt with in section 5.4.

An irrational fear of contagion, evident in the avoidance of physical contact with the AIDS-patient, indicated strong countertransference as a result of lack of knowledge on the modes of transmission of the HIV-virus, despite being well informed on the nature of the HIV-virus and AIDS as a disease. This finding holds a definite implication for practice because it inevitably influences empathic behaviour and successful engagement with the patient. The successful holistic treatment of

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the patient therefore becomes affected, influencing medical treatment negatively as well.

Knowledge on the subject of AIDS and attitudes to these patients did not correlate. It therefore follows that knowledge on the subject of AIDS alone cannot create a more positive attitude towards the patient. It is therefore this very void that leads to negative countertransference, consequently impacting negatively on the therapeutic process in all its facets.

The study has not brought to light any significant correlation between attitudes towards homosexuals and attitudes to AIDS. It may however be speculated that prejudice against homosexuals is prevalent but only subconsciously, and therefore well disguised. Although no significant correlation was recorded for the two variables attitudes to homosexuals and that to AIDS-patients, it seems as if a strong positive relationship exists between these two statistics for three respondents who admitted to being homosexual. One can therefore surmise that the non-judgmental attitude which is part of the repertoire of the social worker, acts as force behind this unbiased reaction. Testing attitudes regarding this theme under discussion may well indicate a difference in outcome to this study, after respondents have become more educated on both of the two themes. This aspect does however need to be researched further.

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The same countertransference feelings do not seem to prevail in cases of treating terminally ill patients, and in treating AIDS-patients, or projecting the self onto these two situations. With the results having indicated that there is no significant correlation in attitudes pertaining to the terminally ill and AIDS-patients, it follows that AIDS is not regarded as yet another terminal illness among respondents, calling for similar skills and knowledge. This could be an indication that the terminally ill and AIDS-patients bring about two different sets of countertransference reactions.

The findings indicate that positive countertransference can result from prolonged exposure to HIV- and AIDS-patients. It is evident that exposure to such patients increases knowledge on HIV and AIDS, releases the worker of the irrational fear of contagion, decreases avoidant behaviour, and results in a more comfortable approach with AIDS-patients.

The responses showed that in general, respondents were comfortable in dealing with issues involving human sexuality, yet they were of the opinion that they did not receive adequate training on the subject. Its implication for practice is clear: countertransference regarding being inadequately equipped with regard to the subject of human sexuality may not surface in the form of

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avoidance behaviour towards these patients concerned, but will necessarily lead to shortcomings in the effective treatment process due to inadequate knowledge on human sexuality and how it is linked to the patient concerned. Generalisation may inevitably result.

5.2. LOBBYING

The responses on the facilities available within the Western Cape for the comprehensive treatment of HIV-infected and AIDS-patients, signify a strong call for more facilities to meet this need. The lack of such facilities results in a lack of comprehensive treatment of such patients, i e from the initial pre- and post-test counselling phase through to the final stage of the illness where death is being awaited, ideally in a quiet and caring environment of health care personnel, with readily access for significant others to the patient concerned. It is therefore imperative that social workers fulfill a lobbying role with regard to patient care in an attempt to meet the broader goal of the protection of human rights, in this case the right to receive adequate medical care as a person who is HIV-infected and/or suffering from AIDS. The lobbying function needs to include pleas to the government and private sector for the financing of and the establishment of more facilities, to meet the needs of paediatrics, those living in townships, with regards to hospital care,

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and community centers for the HIV- and AIDS-patient. This lobbying should especially be motivated by the World Health Organisation resolution on the avoidance of discrimination against persons with HIV and AIDS, and the fact that AIDS is a disease influencing marginalised groups, i e homosexuals and Blacks, whose human rights have largely been neglected and regarded as of minor importance.

5.3. ACCOUNTABILITY

Of great encouragement was the positive attitude of respondents regarding carrying a responsibility and having a role to play within the AIDS-field. This reaction holds positive implications for practice because it serves as necessary energiser to become more knowledgeable on the subject of AIDS as well as better equipped to treat the AIDS-patient. Once allowing themselves to become exposed to the field, awareness of inherent fears and possible discrimination will surface, and can be dealt with in consultation. This, coupled with desensitization in the form of handling an AIDS-case as necessary component in training to become better equipped to work in either a generic capacity, hereby offer counselling to the infected person, or in a clinical capacity, in which case more in-depth work will result, will obviously be a necessary consequence.

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Regarding the responsibility of tracing sexual partners, the responses indicated an ambivalence towards becoming involved in a preventative role. Due to the fact that it holds implications for the further spread of the disease, it needs to be stressed that social workers are ethically responsible in terms of this very issue. It is therefore important that the social worker informs the patient of the limits of confidentiality early on in treatment. The rare circumstances under which breach of confidentiality may be called for, needs to be explained to the patient. It also needs to be emphasised that social workers should make appropriate use of the strength of the therapeutic relationship with the given patient to determine ways to protect the sexual partner(s) of the patient. Sound practice should be used effectively to prevent the disclosure of confidential information without the client's cooperation and permission. High levels of trust need to be maintained by social workers. Furthermore, in cases where the patient's health poses a threat to third parties, the social worker needs to become familiar with legislation and/or policies that pertain to HIV and AIDS. Consultation with attorneys may be necessary, to establish confidential and mandatory reporting procedures in relation to AIDS. In addition to these mentioned aspects, social workers also need to familiarise themselves with standard guidelines regarding informed consent, and how the patient has to be involved both verbally in terms of the use of therapeutic space,

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and in writing. In the final instance, social workers need to be aware of the liability risks involved in AIDS-related cases, which may include being sued for failure to take steps to protect third parties at risk, but also sued by the patient for disclosing confidential information without the permission of the patient involved.

5.4. CONSULTATION AND TRAINING

The important role that consultation plays in rendering effective therapeutic services to the HIV- and AIDS patient are being dealt with in combination with the aspect of training in this section, due to the fact that they cannot be separated as a result of their shared goal, namely the equipping of the social worker with the knowledge and skills necessary within a given field, through identification of issues in the repertoire of the social worker that hinders effective treatment as well as the provision of factual knowledge on the subject concerned.

With regard to the finding that respondents were knowledgeable on the nature of HIV and AIDS but lacked the knowledge on its modes of transmission, resulting in countertransference feelings paralleling fear of contagion, it was evident that clinicians need to become more knowledgeable about the disease, its modes of

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transmission, and its psychological impact on the patient as necessary prerequisite for successful engagement with the patient.

In addition to the abovementioned, other recommendations with regard to training in relation to the research results include that clinicians become more educated on homosexuality in addition to becoming more knowledgeable on AIDS and its modes of transmission. In addition, due to the fact that empathic behaviour on the part of clinicians will also be developed as they are enabled in consultation and support groups to become more introspectively aware of the themes underlying their negative countertransference, and are enabled to freely discuss these feelings, such consultation sessions coupled with support groups for clinicians in private practice are highly recommended for the endurance of their work with AIDS-patients. Due to the isolated nature of their work this may prove to enhance the quality of service delivery in general as well.

Education on the subject of human sexuality is also imperative, coupled with consultation on a readiness to treat homosexuals. It is of utmost importance because ambivalence in treatment of homosexuals due to countertransference is a component hindering a positive attitude towards AIDS-patients, influencing their treatment negatively. Education on human sexuality is

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thus also an imperative recommendation for the enhancement of successful therapeutic work with AIDS-patients because AIDS relates closely to human sexuality as well. Becoming skillful in this area is thus a predominant factor, given the awareness which needs to be developed on the part of the worker regarding acceptance of the person's own sexuality.

Since the study has brought to light the fact that knowledge on the subject of AIDS does not necessarily lessen or negate the fear of contagion amongst others, the indispensable role of consultation needs to be highlighted with regard to this correlational finding as well for the enhancement of therapeutic engagement and successful treatment of AIDS-patients.

AIDS-education and training coupled with exposure to AIDS-patients are therefore necessary for the establishment of a positive attitude towards AIDS-patients. This will result in empathic engagement with and enhancement of a positive therapeutic endeavor on the part of the patient, creating successful outcome of therapy for both the patient and significant others, including the period after the patient has died. In cases where consultation is absent, negative countertransference may prevail, and will it affect survivor counselling immediately, leading to lack of empathic understanding and a failure to engage in a

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meaningful way to establish the rapport necessary for success in treatment. An important recommendation in this regard is that desensitization should form part of AIDS-education if possible, to build in the mechanism of exposure into the repertoire of the clinician who is in the process of becoming adequately equipped for entrance into the AIDS-field therapeutically speaking.

Responses to the aspect of training indicated that respondents were aware of their own need to receive comprehensive AIDS-education to become skillful in the necessary therapeutic engagement and establishment of a meaningful rapport with the patient, to help create a therapeutic atmosphere conducive to the successful outcome of such therapy. Some respondents have attended lectures on AIDS as well as training courses offered by the AIDS Training and Resource Centre (Attic) but still felt insufficiently equipped for such a task. Not even their previous experience within the clinical field made respondents more comfortable with the idea of working with an AIDS-patient because they did not regard it to be possible to marry it. The need that surfaced very strongly, if the other results are kept in mind as well, is for a comprehensive AIDS-education packet which deals with all the aspects of HIV and AIDS, the impact on the lives of those who have contracted the disease, a course on human sexuality and how it relates to work in this field, and the issues involved in therapy with such

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patients. A strong recommendation is thus made for a comprehensive AIDS-education course, designed and offered to clinicians who wish to become better equipped to work in the field of AIDS. Such a course should also be incorporated into the curriculums of courses offered by all schools of social work within South Africa. It is recommended that the course include all the necessary aspects on HIV and AIDS that is of particular relevance for social workers, how the disease impacts on the patient and significant others, issues related to human sexuality with special reference to how it relates to AIDS, and the issues involved in therapy with AIDS-patients and their significant others.

5.5. SUMMARY

The implications for social workers in private practice are far reaching, if attempting to become involved in all the facets which are necessary in the fight against AIDS as an incurable disease. A professional awareness of how the patient's transference reactions impacts on the clinician, and the countertransference which follows, has to be dealt with in a combination of consultation for the duration of therapy with the HIV/AIDS- patient, coupled with becoming equipped in the field of AIDS via an adequate training course on AIDS-education. The social worker also has to become familiar with the legal aspects pertaining to AIDS-issues for protection of the

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professional self regarding liability to third parties, and safeguard the ethical role regarding accountability. In the widespread need for more comprehensive, decentralised facilities for the adequate treatment of HIV-infected and AIDS-patients, the social worker has an important lobbying role to fulfill in the broader plight for human rights for those affected by the disease.

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CHAPTER 6

CONCLUSIONS AND SUMMARY

6.1 SUMMARY

Against the backdrop of the AIDS-pandemic reaching crisis proportions, without any comprehensive medical cure in sight in the nearby future, the role and functions of other health care professionals are increasing in importance because of the political, economic, social, physical and psychological impact of the disease on the HIV- and AIDS-patient. The severe psychosocial impact of the disease compels social workers to contribute their services. The expertise of clinical social workers, including those in private practice, however distinguish them from their counterparts operating in generic settings due to their ability to create a therapeutic milieu conducive to the successful treatment of the AIDS-patient. Given the autonomous nature of their work environment, clinical and generic social workers in private practice are however in an even better position to deal with an AIDS-patient. Several studies have been done both locally and abroad, on the role that knowledge, attitudes and behaviour of health care professionals play with regard to treatment of the AIDS-patient. No such studies have however focused specifically on social workers in private practice as a

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population within the profession. To identify the degree to which knowledge affect the attitudes of social workers in private practice, the writer made use of a self-administered questionnaire. It consisted of 41 close-ended questions and tested knowledge on HIV and AIDS, attitudes to AIDS-patients, attitudes to homosexuals and the terminally ill, as well as exposure to AIDS-patients. A total of 18 social workers completed a set of objective questions on a hypothetical AIDS-sufferer portrayed in a vignette at the beginning of the questionnaire. A Pearson product-moment correlation matrix were constructed from individual scores to assess the degree of correlation among these mentioned variables. Simple two-sample chi-square tests were conducted to compare attitudes of males and females of the population with regard to these variables. The results indicated no significant correlation between knowledge on AIDS and attitudes to AIDS-patients. The same finding was made in relation to attitudes towards homosexuals, the terminally ill, and sexuality in general. The same applied to the difference in attitudes according to gender, but men were more positive towards homosexuals than were females. The only positive correlation that was found, was that between exposure to AIDS-patients and attitudes towards AIDS-patients. It is evident from this finding that the respondents who have had AIDS-patients in therapy, were more positive in their attitudes towards these patients. The findings of this study furthermore suggest that

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social workers in private practice have a negative attitude towards AIDS-patients due to fear of contagion because knowledge on transmission of the disease is lacking.

Desensitization in the form of exposure to AIDS-patients should thus form part of a comprehensive AIDS-education packet for social workers in private practice, which will combine becoming more knowledgeable on HIV- and AIDS-issues with their role in treatment, and to help promote greater success in the holistic treatment of the AIDS-patient. In addition, ambivalence in relation to their role with regard to third parties involved has to be addressed in terms of what accountability entails when operative in the field of AIDS. Lobbying for the rights of HIV- and AIDS-patients in the form of pleas for the provision of comprehensive, desentralised facilities for the treatment of these patients, also appears to be imperative.

6.2. CONCLUSIONS

The research results confirmed the reflection in the literature that persons who have become infected by the HIV virus and those who have contracted AIDS are still today, a decade after the disease first became known to the world, being regarded and treated with suspicion and discriminated against. Even among health care

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professionals who are trained to serve the human race, attitudes are not above reproach. This inference, made in relation to social workers whose professional value base emphasises dignity for and a non-judgmental approach towards individuals in distress, highlights the fact that a near attitude of indifference prevails which parallels that of the wider public in that no serious attempts seemed eminent with regard to combining knowledge with introspection and active consultation to equip the professional self more adequately for engagement in the fight against AIDS given its race against time.

An AIDS-education packet which offers desensitization as part of the training of social workers therefore seems to be a step in the right direction. More is however at stake because of AIDS being singled out as a disease terminal in nature but not necessarily placing similar strains on social workers as did other terminal illnesses before the advent of AIDS. The crisis around the comprehensive and effective treatment of AIDS, highlights prevalent limitations in literature, research and training packets of the past, leading to negative countertransference reactions when confronted with those affected by the spreading infection.

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APPENDIX I

University of Cape Town

STATISTICS ON THE AMERICAS:

Americas	1979-1989 cases	1990 cases	1990 rate	1991 cases	1991 rate	1992 cases	Report dated	Cumulative cases
Anguilla	3	1	10.0	0	0.0	0	30.06.92	4*
Antigua Barbuda	3	3	3.7	0	0.0	0	31.12.90	6
Argentina	542	383	1.2	373	1.1	0	31.12.91	1,298
Bahamas	437	162	66.1	235	95.9	0	31.12.91	834
Barbados	111	61	23.9	78	30.5	30	31.03.92	280*
Belize	11	1	0.6	0	0.0	0	31.03.90	12
Bermuda	135	33	57.9	23	40.4	8	31.03.92	199*
Bolivia	18	7	0.1	16	0.2	2	31.03.92	43*
Brazil	12,445	6,177	4.1	5,914	3 9	168	31.03.92	24,704*
British Virgin Islands	1	2	20.0	1	10.0	0	31.03.92	4*
Canada	4,238	1,050	4.0	788	2.9	40	31.03.92	6,116*
Cayman Islands	5	2	11.8	3	17.6	0	31.03.91	10
Chile	236	117	0.9	147	1.1	0	31.12.91	500
Colombia	900	620	1.9	669	2.0	0	31.12.91	2,189
Costa Rica	148	69	2.3	83	2.7	30	31.03.92	330*
Cuba	63	10	0.1	30	0.3	9	31.03.92	112*
Dominica	10	2	2.3	0	0.0	0	31.12.91	12
Dominican Republic	1,222	238	3.3	162	2.2	20	31.03.92	1,642*
Ecuador	86	42	0.4	51	0.5	0	31.12.91	179*
El Salvador	129	54	1.0	107	2.0	33	31.03.92	323*
French Guiana	191	41	46.6	0	0.0	0	30.09.90	232
Grenada	19	5	4.8	7	6.7	1	31.03.92	32*
Guadeloupe	189	6	1.7	0	0.0	0	24.04.90	195
Guatemala	64	78	0.8	94	1.0	0	31.12.91	236
Guyana	84	61	7.7	85	10.6	28	31.03.92	258*
Haiti	2,456	630	9.7	0	0.0	0	31.12.90	3,086
Honduras	556	586	11.4	453	8.5	0	31.12.91	1,595
Jamaica	139	62	2.5	133	5.4	0	31.12.91	334*
Martinique	127	45	13.2	28	8.2	8	31.03.92	208*
Mexico	5,720	2,403	2.7	950	1.1	489	31.03.92	9,562*
Montserrat	1	0	0.0	0	0.0	0	31.12.91	1
Netherlands Antilles	46	31	16.8	0	0.0	0	15.05.91	77
Nicaragua	4	7	0.2	13	0.3	1	31.03.92	25*
Panama	187	73	3.0	70	2.8	7	31.03.92	337*
Paraguay	14	12	0.3	10	0.2	0	31.12.91	36
Peru	245	141	0.7	155	0.7	73	31.03.92	614*
Saint Kitts & Nevis	24	8	17.4	1	2.2	0	31.03.92	33*
Saint Lucia	18	15	10.5	7	4.9	5	31.03.92	45*
Saint Vincent	21	4	3.6	14	12.5	0	31.03.92	39*
Suriname	48	35	8.3	16	3.7	3	31.03.92	102*
Trinidad and Tobago	563	173	13.5	235	18.1	54	31.03.92	1,025*
Turks and Caicos Islands	18	1	10.0	2	20.0	0	31.12.91	21
USA	140,318	39,249	15.7	35,696	14.2	3,038	31.03.92	218,301*
Uruguay	83	76	2.5	86	2.8	33	30.04.92	278*
Venezuela	896	426	2.2	251	1.2	0	31.12.91	1,573
SUB TOTAL	172,774	53,202		46,986		4,080		277,042

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STATISTICS ON EUROPE:

Europe	1979-1989 cases	1990 cases	1990 rate	1991 cases	1991 rate	1992 cases	Report dated	Cumulative cases
Albania	0	0	0.0	0	0.0	0	30.12.91	0
Austria	387	152	2.0	168	2.2	32	30.03.92	739*
Belgium	668	183	1.9	195	2.0	0	30.12.91	1,046
Bulgaria	7	2	0.0	4	0.0	0	30.12.91	13
Czechoslovakia	19	5	0.0	2	0.0	0	30.12.91	26
Denmark	542	195	3.8	210	4.1	25	30.03.92	972*
Finland	59	15	0.3	26	0.5	0	30.12.91	100
France	10,877	3,722	6.6	3,237	5.7	0	30.12.91	17,836
Germany	5,060	1,274	1.6	1,199	1.5	424	30.03.92	7,957*
Greece	277	135	1.3	147	1.5	0	30.12.91	559
Hungary	32	17	0.2	33	0.3	5	30.04.92	87*
Iceland	13	3	1.2	6	2.3	0	30.12.91	22
Ireland	124	55	1.5	62	1.7	0	30.12.91	241
Israel	113	32	0.7	24	0.5	0	30.12.91	169
Italy	5,852	2,955	5.2	2,802	4.9	0	30.12.91	11,609
Luxembourg	24	9	2.4	12	3.2	0	30.12.91	45
Malta	14	1	0.3	7	2.0	0	30.12.91	22
Monaco	3	2	7.4	2	7.4	0	30.09.91	7
Netherlands	1,205	408	2.7	407	2.7	56	30.03.92	2,076*
Norway	145	53	1.3	54	1.3	11	30.04.92	263*
Poland	29	21	0.1	37	0.1	16	30.04.92	103*
Portugal	414	202	2.0	200	1.9	77	30.04.92	893*
Romania	222	947	4.1	535	2.3	0	31.12.91	1,704
San Marino	1	0	0.0	0	0.0	0	30.09.91	1
Spain	6,157	2,612	6.7	2,786	7.1	0	30.12.91	11,555
Sweden	401	119	1.4	125	1.5	0	30.12.91	645
Switzerland	1,458	429	6.5	341	5.1	0	30.12.91	2,228
Turkey	32	12	0.0	18	0.0	7	30.04.92	69*
UK	3,349	1,068	1.9	1,034	1.8	0	30.12.91	5,451
USSR**	29	23	0.0	20	0.0	0	30.12.91	72*
Yugoslavia	109	70	0.3	75	0.3	19	30.04.92	273*
SUB TOTAL	37,622	14,721		13,768		672		66,783
South East Asia								
Bangladesh	0	1	0.0	0	0.0	0	31.08.91	1
Bhutan	0	0	0.0	0	0.0	0	31.08.91	0
Dem. People's Rep. of Korea	0	0	0.0	0	0.0	0	30.11.90	0
India	40	17	0.0	45	0.0	0	31.12.91	102
Indonesia	6	6	0.0	9	0.0	0	31.12.91	21
Maldives	0	0	0.0	0	0.0	0	30.11.91	0
Mongolia	0	0	0.0	0	0.0	0	14.05.92	0*
Myanmar	0	0	0.0	10	0.0	4	31.03.92	14*
Nepal	2	2	0.0	1	0.0	0	31.08.91	5
Sri Lanka	5	3	0.0	2	0.0	0	30.11.91	10
Thailand	43	54	0.1	82	0.1	0	31.10.91	179
SUB TOTAL	96	83		149		4		332

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STATISTICS ON THE WESTERN PACIFIC:

Western Pacific								
American Samoa	0	0	0.0	0	0.0	0	18.02.92	0*
Australia	1,889	631	3.7	651	3.8	67	30.04.92	3,238*
Brunei Darussalam	1	1	0.4	0	0.0	0	19.12.91	2*
Cambodia	0	0	0.0	0	0.0	0	29.11.91	0*
China†	3	2	0.0	3	0.0	0	28.04.91	8*
Cook Islands	0	0	0.0	0	0.0	0	18.02.92	0*
Fed. States of Micronesia	1	1	10.0	0	0.0	0	22.11.91	2
Fiji	1	2	0.3	1	0.1	0	28.11.91	4*
French Polynesia	13	9	4.9	5	2.7	0	28.11.91	27*
Guam	6	2	1.6	2	1.6	0	13.09.91	10
Hong Kong	32	12	0.2	15	0.3	2	01.04.92	61*
Japan	182	189	0.2	82	0.1	20	30.04.92	473*
Kiribati	0	0	0.0	0	0.0	0	08.11.91	0*
Lao People's Dem. Rep.	0	0	0.0	1	0.0	0	23.04.92	1*
Macao	1	0	0.0	1	0.2	0	28.04.92	2*
Malaysia	12	12	0.1	23	0.1	0	01.05.92	47*
Mariana Islands	0	0	0.0	0	0.0	0	14.11.91	0*
Nauru	0	0	0.0	0	0.0	0	17.12.91	0*
New Caledonia	13	3	2.0	2	1.3	0	16.07.91	18
New Zealand	159	73	2.2	78	2.3	13	29.04.92	323*
Niue	0	0	0.0	0	0.0	0	18.02.92	0*
Palau	0	0	0.0	0	0.0	0	22.11.91	0
Papua New Guinea	16	13	0.3	13	0.3	1	11.05.92	43*
Philippines	41	15	0.0	11	0.0	4	06.05.92	71*
Republic of Marshall Islands	2	0	0.0	0	0.0	0	22.11.91	2
Republic of Korea	5	2	0.0	1	0.0	0	10.07.91	8
Samoa	0	1	0.6	0	0.0	0	18.02.92	1*
Singapore	15	5	0.3	12	0.4	0	28.02.92	35*
Solomon Islands	0	0	0.0	0	0.0	0	19.12.91	0*
Tokelau	0	0	0.0	0	0.0	0	18.02.92	0*
Tonga	2	0	0.0	0	0.0	0	29.11.91	2*
Tuvalu	0	0	0.0	0	0.0	0	31.01.91	0
Vanuatu	0	0	0.0	0	0.0	0	28.11.91	0*
Vietnam	0	0	0.0	0	0.0	0	28.04.92	0*
Wallis and Futuna Islands	0	0	0.0	0	0.0	0	27.05.91	0
SUB TOTAL	2,394	976		901		107		4,378

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APPENDIX II

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STATISTICS ON AFRICA:

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30.06.1992

Africa	1979–1989 cases	1990 cases	1990 rate	1991 cases	1991 rate	1992 cases	Report dated	Cumulative cases
Algeria	45	47	0.2	0	0.0	0	31.08.91	92
Angola	198	93	0.9	130	1.3	0	31.12.91	421
Benin	84	50	1.1	51	1.1	0	30.09.91	185
Botswana	87	91	7.0	72	5.3	27	01.03.92	277
Burkina Faso	906	72	0.8	0	0.0	0	11.06.90	978
Burundi	2,784	521	9.5	0	0.0	0	31.08.90	3,305
Cameroon	134	61	0.5	234	1.9	0	30.04.91	429
Cape Verde	28	4	1.1	0	0.0	0	30.06.90	32
Central African Republic	1,162	702	23.1	0	0.0	0	30.06.90	1,864
Chad	21	38	0.7	165	2.8	0	31.12.91	224*
Comoros	1	1	0.2	1	0.2	0	11.03.92	3*
Congo	1,940	465	20.5	1,077	45.8	0	31.12.91	3,482*
Cote D'Ivoire	3,709	3,189	26.6	3,894	31.1	0	31.12.91	10,792*
Equatorial Guinea	3	2	0.6	2	0.6	2	01.02.92	9
Ethiopia	294	448	0.9	889	1.7	249	31.03.92	1,880*
Gabon	51	66	5.6	98	8.1	0	31.12.91	215*
Gambia	78	46	5.3	56	6.3	0	25.02.92	180
Ghana	1,226	1,011	6.7	903	5.8	0	31.12.91	3,140*
Guinea	82	138	2.4	118	2.0	0	01.07.91	338
Guinea-Bissau	123	34	3.5	0	0.0	0	26.03.91	157
Kenya	9,139	0	0.0	0	0.0	0	31.05.90	9,139
Lesotho	13	10	0.6	21	1.1	0	31.12.91	44
Liberia	5	0	0.0	19	0.7	0	31.12.91	24
Madagascar	2	0	0.0	0	0.0	0	08.03.92	2*
Malawi	7,848	4,226	48.3	0	0.0	0	31.10.90	12,074
Mali	234	104	1.1	0	0.0	0	30.06.90	338
Mauritania	11	5	0.2	10	0.5	0	31.07.91	26
Mauritius	4	1	0.1	5	0.5	1	29.02.92	11*
Mozambique	64	98	0.6	178	1.1	108	30.04.92	448*
Namibia	189	122	6.9	0	0.0	0	31.05.90	311
Niger	80	213	2.8	204	2.5	0	31.12.91	497
Nigeria	48	36	0.0	100	0.1	0	15.03.92	184*
Reunion	47	2	0.3	0	0.0	0	17.05.90	49
Rwanda	2,285	2,204	30.5	2,089	27.8	0	31.12.91	6,578
Sao Tome & Principe	0	2	1.8	4	3.6	0	14.02.92	6*
Senegal	307	118	1.6	127	1.7	96	09.03.92	648
Seychelles	0	0	0.0	0	0.0	0	31.12.91	0
Sierra Leone	27	7	0.2	6	0.1	0	30.04.91	40
South Africa	383	320	0.9	316	0.9	0	21.11.91	1,019
Swaziland	10	20	2.5	41	5.0	0	30.09.91	71
Togo	192	458	13.0	628	17.2	0	31.12.91	1,278*
Uganda	13,278	8,441	44.9	8,471	43.3	0	31.12.91	30,190
United Rep. Tanzania	14,107	7,948	29.1	5,341	18.8	0	31.07.91	27,396*
Zaire	12,337	2,425	6.8	0	0.0	0	31.12.90	14,762
Zambia	2,809	1,393	16.5	1,601	18.2	0	31.12.91	5,803*
Zimbabwe	1,602	4,362	44.9	4,587	45.7	1,963	31.03.92	12,514*
SUB TOTAL	77,977	39,594		31,438		2,446		151,455

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APPENDIX III

University of Cape Town

AIDS RESOURCE CENTERS IN SOUTH AFRICA

ATTICS (AIDS Training, Information and Counselling Centers)

Cape Town	(012) 210 2682/3400
Bloemfontein	(051) 405 8544/28
Durban	(031) 300 3104/3020
East London	(0431) 34 2383
Johannesburg	(011) 725 6710 (Hotline)
	725 6712/3/4
Pietersburg	(0152) 91 4962
Port Elizabeth	(041) 506 1415
Pretoria	(012) 313 7988/7850/7002
Richards Bay	(0351) 31 111 EXT 162/193.

GASA - 6010

(021) 23 6826

HOSPITALS

Somerset Hospital (Cape Town)
(021) 21 3311 EXT 202/3

Addington Hospital (Durban)
(031) 32 2111 EXT 126/637

Edendale Hospital HIV clinic
90331) 95 4911

Tygerberg Hospital infectious diseases clinic
(021) 938 5230.

SAIMR AIDS CENTRE

(011) 725 6551/2

TOLL-FREE NUMBERS

Lifeline Helpline	0800 012322
English	0800 022900
Afrikaans	0800 030010
Xhosa	0800 020044
Zulu	0800 030900
Tswana	0800 0809 424944
Venda	0801 111433
South Sotho	0809 434494
North Sotho	0801 111277.

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APPENDIX IV

University of Cape Town

Dear colleague,

I am Lutricia Maree, and a final year Masters student in clinical social work. In partial fulfillment of the degree, I am required to undertake and complete a research project.

To this end, I am investigating a critical area of social work practice, viz. social workers' perceptions, attitudes, and responses to the spread and management of HIV infection and AIDS in the Western Cape.

Current research stresses the necessity to disseminate HIV- and AIDS-information to social workers in practice, by virtue of the key positions they hold in the community.

It is in this regard that I am appealing to you to respond to the enclosed documents. They comprise of a brief case referral and a questionnaire.

Upon reading the referral letter you are asked to fill in the questions as spontaneously as possible. Some questions are specific to the case, others about AIDS in general.

Your confidential reply will facilitate my completion of the research, and enable us as social workers to participate more actively in the arena of AIDS education and care strategies.

The research has the approval of the Clinical Masters Committee at the School of Social Work (UCT), and a summary of the findings of the study will be made available to you upon completion.

I thank you for your cooperation.

Miss L.E.Maree

University of Cape Town

Please complete the following:

1. AGE ______________________

2. GENDER ______________________

3. RELIGIOUS AFFILIATION (if any)

____

4. SUBURB OF RESIDENCE

____

5. INSTITUTION WHERE PROFESSIONAL QUALIFICATION IN SOCIAL WORK WAS ATTAINED

____

6. YEAR IN WHICH QUALIFICATION WAS ATTAINED

____

7. HIGHEST LEVEL OF QUALIFICATION

____

8. PROFESSIONAL REGISTRATION WITH A COUNCIL

____

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9. MEMBER OF A PROFESSIONAL BODY
(e.g. PSYCHOLOGISTS, FAMILY THERAPISTS)

____

10. OTHER QUALIFICATIONS

____

____

University of Cape Town

Dear Social Worker,

I am referring to you a 39 year old man, Mr Pat Johnson, who resides in Pinelands (Cape Town). I have been treating him medically for the last six months and I am concerned about his psychological well-being. He has consented to my referring him to you.

He had been diagnosed HIV-positive approximately two years ago, and is developing AIDS-related symptoms. These include fatigue, depression,recurrent skin infections and a bout of pneumonia. He also has TB.

He has lost 2 kg since I last examined him a fortnight ago and has developed dermatitis (a skin infection) with skin lesions (sores) over his upper back and arms. Further clinical investigation and treatment indicates that he will probably develop AIDS (Acquired Immuno Deficiency Syndrome) in the future.

He is currently presenting with strong suicidal thoughts and depression. Additionally, his wife is about to file for divorce. He has been retrenched from work, and his family of origin have distanced themselves from him.

Could you kindly assess this person and offer him the necessary social work support.

Yours sincerely,
Doctor Albereti

University of Cape Town

Please answer the following questions:
Circle the appropriate code.

	ANSWER	CODE
1. Have you ever had a patient living with AIDS referred to you for therapy?	YES	1
	NO	2
2. Have you ever renderred clinical social work services to an HIV-positive patient?	YES	3
	NO	4
If yes, how?		
3. Have you ever participated in the treatment of a person living with AIDS?	YES	5
	NO	6
If yes, how ?		

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answer the following questions:
e the appropriate code.

	ANSWER	CODE
4. Have you recently attended any training sessions pertaining to HIV- and AIDS-issues.	YES	7
	NO	8

If yes, please elaborate:
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If no, why not?.................
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ase answer the following section by circling
ır choice. You may also be asked to elaborate
your answer in this section.

	ANSWER	CODE
5. In your opinion are there adequate facilities in the Western Cape for the comprehensive treatment of people with AIDS?	YES	9
	NO	10
	UNCERTAIN	11

If yes, explain.................
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If no, or uncertain, please feel free to comment.
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ease answer the following section by circling ur choice. You may also be asked to elaborate your answer in this section.

	ANSWER	CODE
6. HIV is a viral infection.	YES	12
	NO	13
	UNCERTAIN	14
7. AIDS is primarily a sexually transmitted disease.	YES	15
	NO	16
	UNCERTAIN	17
8. A person who has had one unprotected sexual contact is equally at risk in getting infected as a person who has multiple partners.	YES	18
	NO	19
	UNCERTAIN	20

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ease answer the following section by circling
ur choice. You may also be asked to elaborate
your answer in this section.

	ANSWER	CODE
9. Please specify some of the areas you believe, from your experience, in which you will be able to contribute towards treating the AIDS-patient and his/her significant others for example counselling etc..		
10. Should social workers in private practice administer safe sex information to their clients?	YES	21
	NO	22
	UNCERTAIN	23
11. Would you feel comfortable in using a condom and sexual devices eg. plastic penis/ vagina to demonstrate safe sex to clients?	YES	24
	NO	25
	UNCERTAIN	26
12. Social workers should be responsible for tracing the partners of persons who are HIV-infected.	YES	27
	NO	28
	UNCERTAIN	29
13. A person like Mr. Johnson should abstain from sexual intimacy because of his HIV-infection.	YES	30
	NO	31
	UNCERTAIN	32

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Please answer the following section by circling your choice. You may also be asked to elaborate on your answer in this section.

	ANSWER	CODE
14. Do you think that social workers should wear protective clothing (eg. masks, gloves and gowns) when counselling or giving therapy to a person who who has AIDS?	YES	33
	NO	34
	UNCERTAIN	35

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he following statements and questions require ou to rate according to a scale of true-false o "do not know". Please circle the column that pplies to your immediate response.

	ANSWER	CODE
15. Mr. Johnson has a terminal illness.	TRUE	36
	FALSE	37
	DON'T KNOW	38
16. If I shook Mr. Johnson's hand and his sweat came into contact with a small cut on my hand, I could become HIV-infected.	TRUE	39
	FALSE	40
	DON'T KNOW	41
17. A thorough washing and disinfection of social worker's clothes is necessary after they have had contact with a person like Mr. Johnson.	TRUE	42
	FALSE	43
	DON'T KNOW	44

University of Cape Town

ıe following statements and questions require ıu to rate according to a scale of true-false ı "do not know". Please circle the column that ıplies to your immediate response.

	ANSWER	CODE
18. AIDS is a disease that involves the immune system.	TRUE	45
	FALSE	46
	DON'T KNOW	47
19. Mr. Johnson, according to his diagnosis in the referral letter, should be treated in isolation in hospital.	TRUE	48
	FALSE	49
	DON'T KNOW	50
20. Being tested HIV-positive means that one has AIDS.	TRUE	51
	FALSE	52
	DON'T KNOW	53
21. The sweat of an HIV-positive patient is not contagious.	TRUE	54
	FALSE	55
	DON'T KNOW	56

University of Cape Town

Here is a list of statements which have been made about Mr. Johnson and his disease. Please indicate the extent to which you agree or disagree with them by circling the appropriate two-letter code on the scale below.

trongly Agree	Moderately Agree
SA	MA
oderately Disagree	Strongly Disagree
MD	SD

	ANSWER	CODE
22. Mr. Johnson's disease is a reflection of his lifestyle.	SA	57
	MA	58
	MD	59
	SD	60
23. The following persons living with AIDS are NOT responsible for their disease:		
Contact Sportspersons	SA	61
	MA	62
	MD	63
	SD	64
Blood transfusion patients	SA	65
	MA	66
	MD	67
	SD	68
Homosexuals	SA	69
	MA	70
	MD	71
	SD	72

University of Cape Town

ere is a list of statements which have been made about Mr. Johnson and his disease. Please indicate the extent to which you agree or disagree with them by circling the appropriate two-letter code on the scale below.

Strongly Agree	Moderately Agree
SA	MA
Moderately Disagree	Strongly Disagree
MD	SD

	ANSWER	CODE
Children	SA	73
	MA	74
	MD	75
	SD	76
Prostitutes	SA	77
	MA	78
	MD	79
	SD	80
Heterosexuals	SA	81
	MA	82
	MD	83
	SD	84
Health Care Workers e.g. nurses	SA	85
	MA	86
	MD	87
	SD	88

University of Cape Town

<u>Here is a list of statements which have been made about Mr. Johnson and his disease. Please indicate the extent to which you agree or disagree with them by circling the appropriate two-letter code on the scale below.</u>

Strongly Agree	Moderately Agree
SA	MA
Moderately Disagree	Strongly Disagree
MD	SD

	ANSWER	CODE
Migrant Labourers	SA	89
	MA	90
	MD	91
	SD	92
Motor Vehicle Accident Victims	SA	93
	MA	94
	MD	95
	SD	96
24. More patients like Mr. Johnson are likely to be referred to social workers for social work therapy in future.	SA	97
	MA	98
	MD	99
	SD	100
25. Mr. Johnson has probably had promiscuous sexual relationships with other people.	SA	101
	MA	102
	MD	103
	SD	104

University of Cape Town

ere is a list of statements which have been ade about Mr. Johnson and his disease. Please ndicate the extent to which you agree or isagree with them by circling the appropriate wo-letter code on the scale below.

rongly Agree	Moderately Agree
SA	MA
oderately Disagree	Strongly Disagree
MD	SD

	ANSWER	CODE
26. Social workers have no role in the management of AIDS-patients.	SA	105
	MA	106
	MD	107
	SD	108
27. Patients with a terminal illness make me feel uncomfortable.	SA	109
	MA	110
	MD	111
	SD	112
28. I would prefer not to treat Mr. Johnson if he was bisexual.	SA	113
	MA	114
	MD	115
	SD	116
29. I feel helpless when treating terminally ill patients in my office.	SA	117
	MA	118
	MD	119
	SD	120

University of Cape Town

Here is a list of statements which have been made about Mr. Johnson and his disease. Please indicate the extent to which you agree or disagree with them by circling the appropriate two-letter code on the scale below.

Strongly Agree — SA

Moderately Agree — MA

Moderately Disagree — MD

Strongly Disagree — SD

	ANSWER	CODE
30. I would avoid close physical contact with Mr. Johnson.	SA	121
	MA	122
	MD	123
	SD	124
31. I would rather treat Mr. Johnson if he were a haemophiliac than if he were a homosexual.	SA	125
	MA	126
	MD	127
	SD	128
32. Clinical social work has a major role to play in the treatment of terminally ill patients.	SA	129
	MA	130
	MD	131
	SD	132
33. My university training provided me with adequate information about HIV-infection and AIDS and treating these patients.	SA	133
	MA	134
	MD	135
	SD	136

University of Cape Town

lere is a list of statements which have been nade about Mr. Johnson and his disease. Please indicate the extent to which you agree or lisagree with them by circling the appropriate two-letter code on the scale below.

trongly Agree	Moderately Agree
SA	MA
oderately Disagree	Strongly Disagree
MD	SD

	ANSWER	CODE
34. I would be comfortable in exploring intimate sexual practices with a homosexual client.	SA	137
	MA	138
	MD	139
	SD	140
35. My social work training provided me with a basis for understanding, and dealing with human sexuality concerns.	SA	141
	MA	142
	MD	143
	SD	144
36. I would rather refer Mr. Johnson to a specialized unit dealing with people living with AIDS.	SA	145
	MA	146
	MD	147
	SD	148
37. More emphasis on AIDS education and treatment strategies should be incorporated into the social work syllabus.	SA	149
	MA	150
	MD	151
	SD	152

University of Cape Town

Here is a list of statements which have been made about Mr. Johnson and his disease. Please indicate the extent to which you agree or disagree with them by circling the appropriate two-letter code on the scale below.

trongly Agree — SA

Moderately Agree — MA

oderately Disagree — MD

Strongly Disagree — SD

	ANSWER	CODE
38. I would need to know more about infection control before treating Mr. Johnson.	SA	153
	MA	154
	MD	155
	SD	156
39. I am comfortable in dealing with sexual matters with my clients.	SA	157
	MA	158
	MD	159
	SD	160
40. An infant born with HIV-infection should receive priority in being given expensive and scarce anti-retroviral medication rather than Mr. Johnson.	SA	161
	MA	162
	MD	163
	SD	164
41. I would have difficulty in physically handling an infant/child who has AIDS.	SA	165
	MA	166
	MD	167
	SD	168

University of Cape Town

Geagte Kollega

Ek is Lutricia Maree, tans ´n finale jaar Meestersgraad student in kliniese maatskaplike werk. Ter gedeeltelike vervulling van die graad word daar van my vereis om ´n navorsingsprojek te onderneem.

Gesien teen hierdie agtergrond, loods ek huidiglik ´n ondersoek in ´n kritieke area van maatskaplike werk praktyk, nl. die houdings van maatskaplike werkers t.o.v die verspreiding en hantering van HIV-infeksie en VIGS binne die Wes-Kaap.

Huidige navorsing beklemtoon die belang van die vespreiding van HIV- en VIGS-inligting aan maatskaplike werkers werksaam binne praktykverband, hetsy direkte of privaatpraktyk, gegee die sleutelposisies wat hul binne die gemeenskap vervul.

Dit is dan ook in die lig van hierdie gegewe dat ek ´n beroep op u doen om te reageer op die ingesloto dokumente. Dit sluit ´n oorsigtelike gevalleverwysing en ´n vraelys in.

U word vriendelik versoek om n.a.v die gevalleverwysing sekere daaropvolgende vrae so spontaan as moontlik te beantwoord. Sekere vrae staan in direkte verband tot die betrokke geval, terwyl ander vrae fokus op VIGS in die algemeen.

U vertroulike reaksie sal die voltooing van hierdie navorsing fasiliteer, en as maatskaplike werkers daartoe in staat stel tot meer betekenisvolle betrokkenheid binne die veld van VIGS-opvoeding, assok hulpverlening-strategiee.

Hierdie navorsing geniet die toestemming van die Skool van Maatskaplike Werk (Universiteit van Kaapstad), en ´n opsomming van die studie-bevindinge sal aan u beskikbaar gestel word na afloop van die voltooing daarvan.

Innige dank vir u samewerking.

Mej. L.E.Maree

University of Cape Town

VOLTOOI ASSEBLIEF DIE VOLGENDE:

1. OUDERDOM ______________________

2. GESLAG ______________________

3. KERKVERBAND (INDIEN ENIGE)

____

4. VOORSTAD VAN VERBLYF

____

5. INSTELLING WAAR PROFESSIONELE KWALIFIKASIE(S) IN MAATSKAPLIKE WERK BEHAAL IS.

____

6. JAAR WAARIN KWALIFIKASIE BEHAAL IS.

____

7. HOOGSTE VLAK VAN KWALIFIKASIE.

____

8. PROFESSIONELE REGISTRASIE MET 'N RAAD.

____

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9. LID VAN 'N PROFESSIONELE LIGGAAM (BV. SIELKUNDIGES, GESINSTERAPEUTE).

____

10. ANDER KWALIFIKASIES.

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University of Cape Town

Geagte Maatskaplike Werker

Ek verwys ʹn 39-jarige man, mnr Pat Johnson, woonagtig te Pinelands, Kaapstad, na u. Ek behandel hom die afgelope ses maande medies, en gedurende hierdie tydperk het sy sielkundige toestand ʹn toenemende kwelpunt geword. Hy het sy goedkeuring daaraan verleen dat ek hom na u verwys.

Bykans twee jaar gelede is hy as HIV-positief gediagnoseer, en is sedertdien besig om VIGS-verwante simptome te ontwikkel. Dit sluit in oormatige moegheid, depressie, herhaalde velinfeksies en ʹn aanval van longontsteking. Hy het ook tuberkulose onder lede.

Afgesien daarvan dat hy 2 kg verloor het sedert my vorige ondersoek twee weke gelede, het hy ook dermatitis (ʹn velinfeksie) ontwikkel met velstoornisse (sere) oor sy arms en die boonste gedeelte van sy rug. Verdere kliniese ondersoek en behandeling dui daarop dat hy moontlik VIGS sal ontwikkel in die nabye toekoms.

Tans toon hy sterk selfmoordneigings assok tekens van depressie. Addisioneel gesproke is sy vrou vasbeslote om spoedig ʹn egskeidingsgeding teen die pasient aanhangig te maak. Hy is afgedank by sy werk, en sy familie van oorsprong het hulself van hom distansieer.

Kan u asseblief hierdie persoon assesseer en hom van die nodige maatskaplike werk dienslewering voorsien.

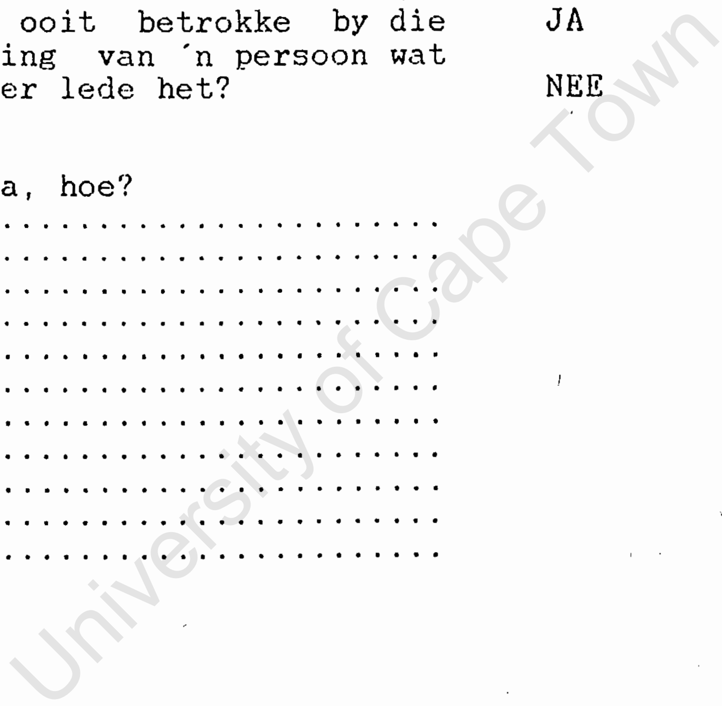
Die uwe,

Dokter Albereti

University of Cape Town

:antwoord die volgende vrae: Plaas ´n sirkel om die :oepaslike kode.

		ANTWOORD	KODE
1.	Was ´n pasient wat VIGS onder lede het al ooit na u verwys vir terapie?	JA	1
		NEE	2
2.	Het u al ooit klinies maatskaplike werk dienste aan ´n HIV-positief getoetsde pasient gelewer?	JA	3
		NEE	4
3.	Was u al ooit betrokke by die behandeling van ´n persoon wat VIGS onder lede het?	JA	5
		NEE	6



Indien ja, hoe?

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antwoord die volgende vrae: Plaas 'n sirkel om die gepaslike kode.

	ANTWOORD	KODE
4. Het u onlangs enige opleidingsessies rakende aspekte rondom HIV-infeksie en VIGS bygewoon?	JA	7
	NEE	8

Indien ja, brei uit asseblief.
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Indien nee, verstrek redes.
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University of Cape Town

Beantwoord asseblief die volgende afdeling deur 'n kring om die toepaslike kode te trek. Daar mag ook in hierdie afdeling van u verlang word om uit te brei op u antwoord.

		ANTWOORD	KODE
5.	HIV is 'n virus infeksie.	JA	9
		NEE	10
		ONSEKER	11
6.	VIGS is primer 'n seksueel oordraagbare siekte.	JA	12
		NEE	13
		ONSEKER	14
7.	'n Persoon wat een onbeskermde seksuele kontak gehad het, loop in dieselfde mate die risiko om infeksie te kry as 'n persoon met veelvuldige seksmaats.	JA	15
		NEE	16
		ONSEKER	17

8. Spesifiseer asseblief sommige van die areas waarbinne u uit ervaring oortuig is u in staat sal wees om 'n sinvolle bydrae te kan maak rakende die behandeling van die VIGS-pasient asook sy naasbestaandes (bv. beraad, ens.):
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University of Cape Town

Beantwoord asseblief die volgende afdeling deur 'n kring om die toepaslike kode te trek. Daar mag ook in hierdie afdeling van u verlang word om uit te brei op u antwoord.

		ANTWOORD	KODE
9.	Behoort maatskaplike werkers in privaat - praktyk inligting rakende veilige seks - metodes aan hulle kliente mee te deel?	JA	18
		NEE	19
		ONSEKER	20
10.	Is daar, na u mening, toereikende fasiliteite binne die Wes-Kaap vir die omvangryke behandeling van persone met VIGS?	JA	21
		NEE	22
		ONSEKER	23

Indien ja, verduidelik.

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Indien nee, of onseker, wat is u kommentaar?

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11.	Sal u gemaklik wees daarmee om 'n kondoom en seksuele toestelle (bv. 'n plastiese penis/vagina) te gebruik ter [illegible]	JA	24
		NEE	25
		ONSEKER	26

University of Cape Town

Beantwoord asseblief die volgende afdeling deur 'n kring om die toepaslike kode te trek. Daar mag ook in hierdie afdeling van u verlang word om uit te brei op u antwoord.

		ANTWOORD	KODE
12.	Maatskaplike werkers behoort verantwoordelik gemaak te word vir die opspoor van vorige seksmaats van persone met die HIV-virus.	JA	27
		NEE	28
		ONSEKER	29
13.	Iemand soos mnr. Johnson moet homself weerhou van enige seksuele intimiteit as gevolg van sy HIV-infeksie.	JA	30
		NEE	31
		ONSEKER	32
14.	Maatskaplike werkers behoort beskermende kledingstukke (bv. maskers, handskoene en oorjasse) te dra wanneer hulle berading of terapie gee aan 'n VIGS-pasient.	JA	33
		NEE	34
		ONSEKER	35

University of Cape Town

Die volgende vrae en stellinge vereis van u om volgens 'n skaal van reg-verkeerd, tot 'weet nie' u antwoord te verskaf. Trek asseblief 'n sirkel om die toepaslike kode wat u onmiddellike respons weergee:

	ANTWOORD	KODE
15. Mnr. Johnson het 'n terminale siekte.	REG	36
	VERKEERD	37
	WEET NIE	38
16. Indien ek mnr. Johnson met my hand sou groet en sy sweet sou met 'n sny in my hand in aanraking kom, kan ek met die HIV-virus besmet word.	REG	39
	VERKEERD	40
	WEET NIE	41
17. Maatskaplike werkers se kledingstukke moet deeglik gewas en ontsmet word na afloop van kontak met iemand soos mnr. Johnson.	REG	42
	VERKEERD	43
	WEET NIE	44
18. VIGS is 'n siekte wat in direkte verband staan met die immuniteitstelsel van die liggaam.	REG	45
	VERKEERD	46
	WEET NIE	47
19. Mnr. Johnson behoort, na aanleiding van sy diagnose in die verwysingsbrief, in isolasie hospitaal - behandeling te ontvang.	REG	48
	VERKEERD	49
	WEET NIE	50

University of Cape Town

Die volgende vrae en stellinge vereis van u om volgens ´n skaal van reg-verkeerd, tot ´weet nie´ u antwoord te verskaf. Trek asseblief ´n sirkel om die toepaslike kode wat u onmiddellike respons weergee:

	ANTWOORD	KODE
20. Om HIV - positief te wees impliseer dat die persoon VIGS onder lede het.	REG	51
	VERKEERD	52
	WEET NIE	53
21. Die sweet van ´n HIV-positiewe pasient is nie aansteeklik nie.	REG	54
	VERKEERD	55
	WEET NIE	56

University of Cape Town

Onderstaande vind u 'n lys van stellings met verwysing na mnr. Johnson en sy siekte. Dui asseblief aan in watter mate u daarmee saamstem of verskil deur 'n sirkel om die toepaslike kode soos op die skaal hieronder aangedui, te trek:

STEM STERK SAAM SSS

STEM MATIG SAAM SMS

STERK GEKANT TEEN SGT

MATIG GEKANT TEEN MGT

	ANTWOORD	KODE
22. Mnr. Johnson se siekte is 'n weerspieeling van sy lewensstyl.	SSS	57
	SMS	58
	SGT	60
	MGT	61
23. Die volgende VIGS-lyers is NIE verantwoordelik vir hulle siekte:		
Kontaksportpersone	SSS	62
	SMS	63
	SGT	64
	MGT	65
Bloedoortappingspasiente	SSS	66
	SMS	67
	SGT	68
	MGT	69

University of Cape Town

Onderstaande vind u ´n lys van stellings met verwysing na mnr. Johnson en sy siekte. Dui asseblief aan in watter mate u daarmee saamstem of verskil deur ´n sirkel om die toepaslike kode soos op die skaal hieronder aangedui, te trek:

STEM STERK SAAM SSS	STEM MATIG SAAM SMS
STERK GEKANT TEEN SGT	MATIG GEKANT TEEN MGT

	ANTWOORD	KODE
Homoseksuele	SSS	70
	SMS	71
	SGT	72
	MGT	73
Kinders	SSS	74
	SMS	75
	SGT	76
	MGT	77
Prostitute	SSS	78
	SMS	79
	SGT	80
	MGT	81
Heteroseksuele	SSS	82
	SMS	83
	SGT	84
	MGT	85

University of Cape Town

Onderstaande vind u 'n lys van stellings met verwysing na mnr. Johnson en sy siekte. Dui asseblief aan in watter mate u daarmee saamstem of verskil deur 'n sirkel om die toepaslike kode soos op die skaal hieronder aangedui, te trek:

STEM STERK SAAM SSS

STEM MATIG SAAM SMS

STERK GEKANT TEEN SGT

MATIG GEKANT TEEN MGT

	ANTWOORD	KODE
Gesondheidswerkers (bv. dokters en verpleegsters)	SSS	86
	SMS	87
	SGT	88
	MGT	89
Trekarbeiders	SSS	90
	SMS	91
	SGT	92
	MGT	93
Slagofffers van motorongelukke	SSS	94
	SMS	95
	SGT	96
24. In die toekoms sal meer pasiente soos mnr. Johnson waarskynlik vir maatskaplike werk terapie verwys word.	SSS	97
	SMS	98
	SGT	99
	MGT	100

University of Cape Town

Onderstaande vind u ´n lys van stellings met verwysing na mnr. Johnson en sy siekte. Dui asseblief aan in watter mate u daarmee saamstem of verskil deur ´n sirkel om die toepaslike kode soos op die skaal hieronder aangedui, te trek:

STEM STERK SAAM SSS

STEM MATIG SAAM SMS

STERK GEKANT TEEN SGT

MATIG GEKANT TEEN MGT

	ANTWOORD	KODE
25. Mnr. Johnson het waarskynlik veelvuldige seksuele verhoudinge gehad.	SSS	101
	SMS	102
	SGT	103
	MGT	104
26. Maatskaplike werkers het geen rol om te vervul in die hantering van VIGS-pasiente nie.	SSS	105
	SMS	106
	SGT	107
	MGT	108
27. Pasiente met ´n terminale siekte laat voel my ongemaklik.	SSS	109
	SMS	110
	SGT	111
	MGT	112
28. Ek sou eerder verkies om nie vir mnr. Johnson te behandel indien hy biseksueel was nie.	SSS	113
	SMS	114
	SGT	115
	MGT	116

University of Cape Town

Onderstaande vind u 'n lys van stellings met verwysing na mnr. Johnson en sy siekte. Dui asseblief aan in watter mate u daarmee saamstem of verskil deur 'n sirkel om die toepaslike kode soos op die skaal hieronder aangedui, te trek:

STEM STERK SAAM SSS — STEM MATIG SAAM SMS

STERK GEKANT TEEN SGT — MATIG GEKANT TEEN MGT

	ANTWOORD	KODE
29. Ek voel hulpeloos wanneer ek terminale pasiente in my kantoor terapeuties behandel.	SSS	117
	SMS	118
	SGT	119
	MGT	120
30. Ek sou naby fisiese kontak met mnr. Johnson vermy.	SSS	121
	SMS	122
	SGT	123
	MGT	124
31. Ek sou mnr. Johnson eerder behandel indien hy 'n bloeier in plaas van 'n homoseksueel was.	SSS	125
	SMS	126
	SGT	127
	MGT	128
32. Kliniese maatskaplike werk het 'n belangrike rol om te vervul ten opsigte van die behandeling van terminale pasiente.	SSS	129
	SMS	130
	SGT	131
	MGT	132

University of Cape Town

Onderstaande vind u 'n lys van stellings met verwysing na mnr. Johnson en sy siekte. Dui asseblief aan in watter mate u daarmee saamstem of verskil deur 'n sirkel om die toepaslike kode soos op die skaal hieronder aangedui, te trek:

STEM STERK SAAM — SSS

STEM MATIG SAAM — SMS

STERK GEKANT TEEN — SGT

MATIG GEKANT TEEN — MGT

	ANTWOORD	KODE
33. My universiteitsopleiding het my genoegsaam toegerus met inligting rakende HIV-infeksie en VIGS, asook die behandeling van hierdie pasiente.	SSS	133
	SMS	134
	SGT	135
	MGT	136
34. Ek sou gemaklik daarrmee wees om intieme seksuele praktyke met 'n homoseksueel te verken.	SSS	137
	SMS	138
	SGT	139
	MGT	140
35. My maatskaplike werk opleiding het my voorsien van 'n basis waarop begrip en vaardighede met betrekking tot menslike seksualiteitsaangeleenthede berus.	SSS	141
	SMS	142
	SGT	143
	MGT	144
36. Ek sou mnr.Johnson eerder na 'n gespesialiseerde eenheid verwys waar die fokus berus op die hantering van persone met VIGS.	SSS	145
	SMS	146
	SGT	147
	MGT	148

University of Cape Town

Onderstaande vind u ´n lys van stellings met verwysing na mnr. Johnson en sy siekte. Dui asseblief aan in watter mate u daarmee saamstem of verskil deur ´n sirkel om die toepaslike kode soos op die skaal hieronder aangedui, te trek:

STEM STERK SAAM
SSS

STEM MATIG SAAM
SMS

STERK GEKANT TEEN
SGT

MATIG GEKANT TEEN
MGT

		ANTWOORD	KODE
37.	VIGS-opvoeding en behandeling-strategiee behoort geinkorporeer te word in die maatskaplike werk leerplan.	SSS	149
		SMS	150
		SGT	151
		MGT	152
38.	Ek benodig meer inligting rakende infeksie - beheer alvorens ek mnr. Johnson kan behandel.	SSS	153
		SMS	154
		SGT	155
		MGT	156
39.	Ek is gemaklik daarmee om aspekte rakende kliente se seksualiteit aan te spreek.	SSS	157
		SMS	158
		SGT	159
		MGT	160
40.	´n Baba wat gebore is met HIV-infeksie behoort voorkeurbehandeling met duur anti-retrovirus medikasie te geniet bo mnr. Johnson.	SSS	161
		SMS	162
		SGT	163
		MGT	164

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