

**PSYCHOLOGICAL EXPLANATIONS
IN HIV/AIDS COUNSELLING**

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ABSTRACT

This research investigated the extent to which explanations of the aetiology, course, treatment, and prognosis of Human Immuno-Deficiency Virus (HIV) and Acquired Immuno-Deficiency Syndrome (AIDS) are shared or differ between African health workers (counsellors) and their African clients who are affected. Medical anthropology and constructionist theory provided theoretical frameworks to explore the significance and meaning of explanations as well as implications for counselling objectives. A qualitative methodology, drawn from theoretical models which emphasize the cultural construction of explanations of disease, was used.

Findings suggest that counsellors' explanations are medical and objective with passive notions of bodily processes, while clients' explanations reflect subjective, personal experiences with the condition attributed to active human agency, supernatural and natural powers. Both counsellors and clients use personal characteristics, social stereotypes and people's actions as determinants for infection. The findings suggest that clients use these to empower themselves in order to cope with the disease, while counsellors use them to assert their power both over clients and in the health care systems; and thus contribute to obstacles in counselling. Suggestions for addressing issues in HIV/AIDS counselling and recommendations for future research in this area are included.

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CHAPTER 1 : THEORETICAL FRAMEWORK

INTRODUCTION

This research aims to explore peoples' explanations of the aetiology, transmission and course of Human Immuno-Deficiency Virus (HIV) and Acquired Immuno-Deficiency Syndrome (AIDS). It investigates the extent to which explanations of HIV/AIDS are shared or differ between African health workers who offer counselling and their African clients who are affected with HIV/AIDS.

The primary hypothesis is that HIV counselling and training enculturates people within a particular view of illness which may not be shared by their clients. Peoples' explanations of HIV/AIDS will be based on theoretical frameworks with the view that the explanations of illness are largely, culturally construed. These frameworks, which consider the role of culture, will reflect the effectiveness of the counselling process. The analysis will help in exploring people's understanding of HIV/AIDS but will also explore how this understanding relates to the counselling objectives.

The study was undertaken to investigate explanations in HIV/AIDS counselling of the participants from the Cape Town area. It elicits the explanatory models of illness of two sets of participants, those who had received training in counselling and the clients, who had received HIV/AIDS counselling and were diagnosed with HIV/AIDS.

1.1 CONTEXT OF THE STUDY

It is important to examine the history of the origins and understanding of HIV and AIDS and how these have evolved over the years, both locally and worldwide. The history will

provide a background with which to examine the link between the explanations and the kinds of explanations or misconceptions that people may have about the disease today.

The history of HIV infection and AIDS dates back to the early 1980's when the first cases of people infected with HIV were reported in the United States of America amongst the homosexual population (AIDS Health Promotion Exchange, 1994). The term AIDS was officially coined in the USA. It was then understood to be a part of a larger set of a category of sexually transmitted diseases, in particular a disease suffered by homosexuals suffered as a direct result of their sexual behaviour or related group practices (Whiteside, 1994).

Other accounts of the origins of HIV infection and AIDS speculate that the disease originated from Haiti or Africa (Serwada & Katongole-Mbidde, 1990). In Africa, the first known case was reported was in Kenya in 1984 (AIDS Health Promotion Exchange, 1994). By 1987, a number of African countries had reported several hundreds of HIV infected people. The pattern was, however different in that it was originally predominant amongst the those who were the urban elite and those considered to be sexworkers (Whiteside, 1994).

It can be seen, justly, that from the two examples there were two predominant mindsets in terms of the American and African origins of AIDS. Secondly, in both these continents, the social character of individuals or groups of people affected with HIV and AIDS was seen to be different from that of general society.

In South Africa, the origins of the epidemic had a pattern similar to that of the United States in that the first component was found to be predominant in men who had sexual intercourse with men (Carswell, 1992). Two patterns were identified along racial lines: the first being the homosexual pattern in the white population was reported in 1982; the second, predominantly in the African heterosexual population, was reported in 1987

(Whiteside, 1994). Within the heterosexual population, there is an increase in the number of women of childbearing age who are likely to pass on the virus to their unborn babies and to their partners, as well as the men who may pass it on to their female partners (Christie, 1991). Because HIV/AIDS is currently widespread within the black heterosexual population, it seems reasonable to explore the research question within this population.

Previous responses to the epidemic in this country have not been adequate (Christie, 1991; National AIDS Convention for South Africa, 1994-95). AIDS was instantly politicised and was seen by the right wing as divine strategy to prevent the population flood and to harass the exiles returning to the country. On the other hand the left wing pointed to the possibility of the virus being developed in laboratories of imperialist countries and to wipe out the black population (Christie, 1991). Whiteside (1994, page 151) maintains that perceptions about the disease developed along racial lines whereby young blacks saw it as a white disease and young whites saw it as a black disease.

On a broader level, it is recognised that the country's socio-political conditions have contributed to its spread (Whiteside, 1994). While a link has been identified between the spread of the disease and the breakdown in societal norms and values, leading to greater incidence of high risk behaviour, it is widely recognised that factors such as cross-border migration, refugees, conflict and civil war, militarisation, drought, poverty, high levels of sexually transmitted diseases, rural urban linkages and the status of women in society exacerbate the problem (Whiteside, 1994).

Another compounding problem is its nature which is characterised by a long incubation period before the infected person develops signs of becoming ill (Whiteside, 1994). The rate at which the disease is growing has implications for social and health services. Not only is it a threat to families in terms of loss, reduction of employment possibilities, decreasing life span, thus placing demand on state welfare etc, it also poses a threat in

terms of finance and human resources in hospitals and agencies providing services for patients and their families (Christie, 1991).

Attempts to deal with the problem were first made in about 1987 when an AIDS Advisory Group (AAG) was established. This was followed by the establishment of the AIDS Centre for the South African Institute for Medical Research which was later used as a model to establish AIDS Training and Information Centres (ATICCS) in several major towns (Christie, 1991).

✶ At present ATICCS represent the total government resources for training, information and counselling and in most instances serve as a back-up support for the health sector as well as for other departments which have become responsible for AIDS work.

In 1990, a government body was established to boost awareness and initiate prevention campaigns in both the public and the private sector (Christie, 1991). At the same time, organisations such as the African National Congress (ANC), the South African Council of Churches, South African Black Social Workers Association, and the National Primary Progressive

Health Care Network, trade unions and other bodies initiated a coordinated effort and committed themselves to combat the disease. The ANC and its alliances committed themselves to placing the struggle for the prevention and control of the HIV/AIDS epidemic within the broad struggle for democratic transformation in South Africa (Christie, 1991).

In 1992, the AIDS Unit of the Department of National Health and Population Development (DPHPD) and the ANC Health Department set up a steering committee comprising apart from themselves, the business sector, trade unions, churches, and civic organisations. At a conference held in the same year, a National AIDS Strategy was

developed which listed education, counselling, prevention, health care, welfare human rights, law reform and socio-economic issues as priorities. The steering committee was then named the National AIDS Coordinating Committee of South Africa (NACOSA) and undertook to establish regional NACOSAS. Both the regional and national structures were to combine their efforts in developing and implementing the National AIDS Strategy. This was adopted by the Government of National Unity (Christie, 1991).

Today, AIDS is one of the most prevalent diseases threatening South African society. Latest statistics reveal that the problem covers a wider population range. The number of infected adults doubled in 1992-93 and this was estimated to be about six million (National AIDS Convention, 1994-95). This number is estimated to double after every 12 months (AIDS Scan, 1994). It is also estimated that by the end of 1994, two million people were infected in South Africa and that by the year 2005, one quarter of the country's population would be infected (AIDS Scan, 1994). Attention from the World Health Organisation (WHO) focused on care and treatment as a strategy, an essential precondition to other preventative initiatives (Bor & Miller, 1991).

* The emergence of counselling in primary and secondary prevention of HIV and AIDS was aimed at reducing psychological morbidity. It was also aimed to equip people with information so that they can cope better with the disease and its progression (Bor & Miller, 1991).

* In examining the developments in HIV and AIDS since the first cases were first reported and how the disease became associated with personality and social stereotypes, it is important to discuss counselling as one of the essential intervention tools for challenging some of the misconceptions that people developed about the disease. It seems worthwhile to begin by exploring counselling and its significance in HIV infection and AIDS.

1.2 THE ROLE OF COUNSELLORS AND COUNSELLING IN HIV/AIDS

Counselling is a complex interaction between a counsellor and a client. It is often seen as a neutral process but in reality involves two people who bring into the counselling situation their respective knowledge and worldview (Sue, 1990). One of the strategies for the prevention of the spread of the HIV/AIDS is through counselling (Stein, Steinberg, Allwood, Karstaed & Brouard, 1994).

Counselling objectives in HIV and AIDS amongst other things include disseminating biomedical information, providing support and guidance in problem-solving and decision-making for the patient before and after testing (Stein, *et al*, 1994). They aim to reduce psychological problems, providing information that will enable the client to cope better with the disease and manage its progression (Bor & Miller, 1991).

The assumption, therefore, is that central to the counselling process is the realisation that it is only to the extent that the patient understands and accepts the biomedical explanation of HIV and AIDS that the behaviour may become consonant with the prevention, management and treatment objective (Stein *et al*, 1994).

The development of HIV and AIDS counselling evolved through a process of innovation and experimentation. It had to define its boundaries within the context of health care and treatment and the intricate roles and responsibilities of respective health professionals who do counselling (Bor & Miller, 1991). In South Africa, the responsibility for counselling in hospitals falls on social workers, psychologists and doctors whereas a larger number of people who need counselling are seen by professional nurses in day hospitals and clinics. In a context where a large number of African patients are seen by white doctors, black counsellors as health providers, often function as both linguistic and cultural intermediaries between the patient and the doctor (Stein *et al*, 1994). They are often at the forefront in terms of explaining the biomedical model of HIV/AIDS, while

they have access to, 'any socio-cultural disjunctions or linguistic confusions and or ambiguities which may decrease patient comprehension and compliance' (Stein *et al*, 1994).

In order to understand how people understand HIV and AIDS, it should be known that counselling cannot be separated from the broader social context (Sue, 1990). It is useful therefore to consider how various theories explain the impact of culture on illness and the implications it may have for the counselling process.

1.3 CULTURE

Mkhize (1994, page 9) views culture as 'basic assumptions that are invented, discovered and developed by a group in a struggle to cope with problems of external adaptation and internal integration'.

Helman (1994, page 2), on the other hand, defines culture as 'a set of guidelines (both implicit and explicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally and how to behave in it in relation to other people, to supernatural forces or gods and to the natural environment'.

Culture plays many roles in society such as transmitting guidelines from one generation to another, and enabling people continuously to understand and learn about the world through the process of enculturation (Helman, 1994).

Another role served by culture is that of dividing or categorising people. One of the ways in which culture divides people is by creating subdivisions or subcultures within a given society. The medical profession is one such entity where members of the group develop

their own concepts and distinctive characteristics although they are part of the larger culture (Helman, 1994).

According to the components of these definitions, there appear to be two dimensions. One of these is static and describes the culture into which a person is born and where members of society are seen as passive recipients of information and experience. The other conceptualisation of culture is dynamic. It takes into account factors such as religion, ethnicity, and the profession all of which influence culture.

The static and dynamic conceptualisations of culture not only make possible the examination of the culture into which people are born, but also the way in which knowledge and experience alters people's cultural position at any given moment. In terms of this model of culture, it is possible to explore variations in cultural meaning, even amongst people who share a common ethnic identity. In particular, it can accommodate the variations introduced by education, status. This suggests that medically trained personnel and those who do not share the same training might have different conceptions of an illness such as HIV/AIDS. While cultural positions are not far from one another, differences might be enhanced where models of disease are available.

1.4 CULTURE AND ILLNESS

The conceptualisation of culture as fluid and determined by education and experience leads to the possibility of examining its medical and non-medical cultures and the way in which these relate to conceptions of illness. Helman, (1994, page 107) describes illness as 'what the patient feels when he goes to see a doctor and 'disease' as what the patient acquires when he leaves the doctor's office'. Illness is described as the subjective feelings and responses of the individual and those around him.

Confirmation by the clinician is most important for the patient. In order for this confirmation to take place (Helman, 1994) argues, there must be consensus among those concerned on what constitutes health and abnormal symptoms. Helman (1994), also demonstrates the way in which an ill person may draw attention to the changes and distress thereby drawing support, care and attention.

Knowledge and practice of biomedicine are socially and culturally construed in much the same way as the illness experience and behaviour. The medical practitioner, however, has his knowledge base from scientific rationality and all assumptions and hypotheses must be tested and validated under objective empirically controlled conditions (Kleinman, 1980). The model of modern medicine is aimed mainly at exploring, discovering and quantifying physio-chemical information about the patient. However, the clinical encounter becomes influenced by the practitioner's personality, training, speciality, experience and the socio-cultural context of the consultation (Helman, 1990). The biomedical model and patient's worldview represent their respective realities. Both the doctor's and patient's health views are used to interpret reality in a meaningful way to both of them. This enables the patient or therapy management team to conclude or revise etiological interpretations of a condition at various stages in its treatment (Good & Good, 1980).

This discussion has allowed for an examination of the ways in which illness, knowledge and practice are products of culture. In order to understand how people explain disease manifestation, the different approaches that recognise the significance of cultural understanding for interpretations of illness are discussed. These approaches demonstrate the ways in which illness and disease may be understood within a framework of cultural meaning. The main theoretical ideas are drawn from medical anthropology.

1.5 MEDICAL ANTHROPOLOGY

To further understanding of the research question, theorists in medical anthropology explain the realities of health institutions and how they differ from those of the patients.

Traditional medical epistemology has always been oriented towards biological phenomena. This view recognised that an illness should be traceable to an organic cause in order to be considered as such (Carson *et al*, 1988). It focuses on the diagnosis of somatic dysfunction and the recognition of symptoms with underlying biological disorder (Good & Good, 1980). The basic assumption of this model is that the biological aspects in illness have more clinical significance than psychological and socio-cultural issues (Kleinman, 1986). One of the reasons given is that health professionals who are trained in scientific medicine make use of that world 'view to explain phenomena.

Health is defined by referring 'to physical and biochemical parameters such as height, weight, blood count, haemoglobin level, respiratory rate or visual capacity' and that for each of these there is a description of normal bodily responses (Helman, 1994, page 103). Health professionals. diagnose and decide on the mode of treatment for the patient. This position is even adopted within mental health where the psychiatrist, as a scientist, attempts to make unbiased observations and an accurate diagnosis as well as offer treatment which will alleviate the symptoms. These are all based on a scientific body of knowledge which is alien to the patient (Lipsedge & Littlewood, 1982).

It has been argued that the relationship between the practitioner and the recipient exists on the basis of power differentials with respect to who defines illness and its parameters, treatment and the rationale and that the patient who assumes the sick role has little or no say in these (Helman, 1994).

The biomedical model has increasingly been criticised in the field of medical anthropology where the integration of medical and anthropological aspects of health have taken place (Swartz, 1991a). The criticisms evolved because members of the medical fraternity (whose orientation was biomedical) were not familiar with the popular beliefs of their patients. The patient's seemingly erratic decisions and non-compliant behaviour were often made in the face of illness (Kleinman, 1986). The criticisms include inter alia, its failure to take into account the social and psychological dimensions of ill health, and the context in which illness occurs, which in turn determines the meaning of the disease for the individual patient (Kleinman, 1980). Medicine also fails to include the personal and social aspects of illness, its meaning for the sick and for those related (Good & Good, 1980, Kleinman, 1980). Lastly, there is a tendency of the clinicians to treat healing as if it were a independent, culture-free process (Kleinman, 1980).

In view of the above discussion and criticisms, it appears that the medical model is increasingly being recognised as one of the many ways of viewing illness. While it may be still dominant in some medical contexts, there is an increasing recognition that non-medical people may not hold these assumptions.

Theories in medical anthropology have stressed the need for the acknowledgement and recognition of models to explain, accommodate the negotiation of illness and thus render appropriate care (Reynolds & Swartz, 1993).

1.6 EXPLANATORY MODELS

The increasingly challenging nature of developments in medical anthropology has opened the possibility of examining different kinds of explanations of disease and illness within the framework of cultural meaning. One method is by looking at Kleinman's notion of an explanatory model. He developed the concept of explanatory model as a framework to

provide a means of exploring and understanding how 'illness is patterned, interpreted and treated' (Helman, 1994, page 111).

It also investigates how cognitive orientations open or close avenues of careseeking (Kleinman, 1980). Explanatory models (EMs) are defined as 'the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process' (Helman, 1994, page 105). Furthermore, explanatory models are marshalled as a way of responding to particular episodes of illness, and cannot, therefore, be likened to beliefs about illness generally held by a society (Helman, 1994).

EMs are cultural tools which are dynamic in nature and are used to interpret some form of reality such as bodily sensations or feelings. They link possible causes with predicted consequences thereby defining the nature with predicted appropriate action (Good & Good, 1980). According to Kleinman, EMs tend to be idiosyncratic and change over time, in that some of their characteristics are vagueness, multiple meanings, frequent changes and lack of clear boundaries between ideas and experience (Helman, 1994). Doctors' EMs are also organised in response to particular illness episodes, but are mostly based on 'single causes of scientific logic'. When patients consult doctors, this results in transactions between lay and medical EMs of a particular illness. The predominance of EMs in any given situation often mirrors power imbalances in the social, political, economic factors and religious ideology in a given society (Swartz, 1991a; Helman, 1990).

EMS are also influenced by the physical context, social class, gender, age, personality and cultural factors. Therefore, the background and the training of the clinicians give them the legitimate power to mould the patient's EMS and fit them into the medical model of the disease, rather than allow the patient's own perspective of illness to emerge. Helman (1990), identifies five aspects of illness that are provided by explanatory models these being :

- aetiology of the condition
- timing and the mode of onset
- pathophysiological processes
- the history and the severity
- the appropriate treatments

There are also explanations called lay beliefs about health. These explanations are derived from awareness of people's body of knowledge about health, illness and their beliefs about these (Helman, 1990). These also originate from shared cultural experiences such as superstitions, religion and politics and invariably interact with scientific knowledge of health issues (Aggleton, Homans, Mojsa, Watson & Watney, 1989). Helman maintains that lay theories of the aetiology of illness are multicausal and postulate a variety of causes acting together at a particular time. The degree of elaboration in aetiology of illness varies with factors such as education, knowledge of traditional medicine, knowledge of biomedicine (Pool, 1994).

1.6.1 Aetiology of illness

The aetiology of illness is seen to lie within four domains in the patient, the natural, the social or the supernatural world (Helman, 1990).

1. **The patient:** the causes of ill-health are located within the individual. This is common in conditions such as alcoholism, sexually transmitted diseases and to some extent, AIDS. This view is predominant in the modern medicine and may be important in determining whether people take responsibility for their health or whether they see the origin, and curing, of illness as being beyond their control.

2. **The natural world:** this is commonly climate (i.e cold, heat etc); infections through animal contact (i.e birds); and environmental irritants (i.e poisons, food additives, and smoke).
3. **The social world:** ill-health is blamed on other people. This is often through sorcery, witchcraft and 'the evil eye' (Helman, 1994, page 124). Illness and other forms of misfortune are ascribed to interpersonal malevolence. Helman argues that the origins of ill-health are a common feature in small and pre-industrial societies. This, however, may not be the case with minor ailments.
4. **The supernatural world:** the view on the aetiology of illness ascribes ill-health to gods, spirits and ancestral shades. In this regard, illness is seen as 'a divine punishment for sinful behaviour' from God or ancestral spirits who have been offended. In some instances, illness may be ascribed to 'malevolent disease bearing spirits' (Helman, 1994, pages 126-127).

Although considerable work has been undertaken into the medical and scientific research on HIV infection and AIDS, few studies have looked into the lay beliefs about HIV transmission and AIDS with the exception of Aggleton *et al* (1989). There are five lay beliefs about HIV infection and AIDS which he identifies.

1.6.2 Lay beliefs about HIV/AIDS

The lay explanations about illness already discussed are derived from an awareness of people's body of knowledge about illness and beliefs about that knowledge. Aggleton *et al*'s exploration of the lay beliefs about HIV and AIDS demonstrates how the language that people use creates misconceptions (Aggleton *et al*, 1989).

1. Aggleton *et al* (1989, page 58) attribute the first lay beliefs to language. The lay beliefs emanate from the notion that there is an 'AIDS virus'. This often leads to

confusion between HIV virus whose modes of transmission are well understood and AIDS, a syndrome of some 30 distinct medical conditions. There is further argument that HIV leads to consequences which are prior to, and sometimes independent of, AIDS. An AIDS virus, therefore, rather gives the impression that it is the cause of the infection rather than one of its outcomes.

The second phrase 'AIDS carrier' is also misleading in that it portrays a set of images about contagion and plague, thus invoking 'medically unjustified deep seated fears about possible contagion' (Aggleton *et al*, 1989, page 58). This notion implies that people with AIDS are threatening rather than being threatened themselves. Furthermore, it makes it difficult for people to distinguish between being infected with HIV and what it means to have AIDS.

2. Aggleton *et al's* second lay belief explains AIDS as originating from divine retribution or supernatural forces. According to this view, AIDS has been unleashed on the world, and upon certain kinds of people such as gay men and prostitutes because they have through their actions, 'infringed a divinely inspired natural social order'. Other lay beliefs view AIDS as originating from or manufactured in research laboratories, in genetic engineering or biological warfare to wipe out certain groups. A further explanation suggests that AIDS is, the result of pollution or of ecological instability precipitated by the attempts to meddle with the environment (Aggleton *et al*, 1989).
3. Aggleton *et al* cite the third set of beliefs to be xenophobic and cites AIDS as originating from other countries or communities. Lay beliefs about AIDS having an African origin have been reported by writers of popular and scientific texts. In some literature, these beliefs are not presented as theories but as facts. Another set of lay beliefs about AIDS explains why some people develop AIDS and others do not. This makes it possible for there to be a distinction between two ideas. The

endogenous idea sees AIDS as originating from some quality of the person rather than as a result of infection. This idea purports that some people may be predisposed to develop AIDS because of the kind of person they are; that AIDS is lurking within all people and that it only needs the right circumstances to set it off. The second set of ideas is the exogenous with the notion that AIDS can be found outside or around the person, that it is around everyone and regardless of behaviour, he/she is at risk of infection.

4. The fourth set of lay beliefs identifies people, situations and activities that are perceived as particularly risky. The notion in this case is that some interviewees emphasize the role that chance and bad luck may play in determining whether or not they become infected (Aggleton *et al*, 1989). These beliefs play a role in determining the extent to which people take effective steps to safeguard themselves from possible risk of infection by selecting their partners with care. Lay beliefs of risk have been influenced by media portrayals of AIDS as a disease of social difference and as one which has serious and debilitating consequences.
5. Lastly, Aggleton *et al* distinguish between those who are supposedly innocent and those who are guilty victims of infection. Those who are innocent include haemophiliacs, blood transfusion recipients, children and married partners of those who engage in extra marital relationships. Gays, drug users, sex workers, the promiscuous and bisexuals are seen as guilty. These lay beliefs, according to Aggleton *et al* (1989), do not arise from rational thought but from moral judgement about acceptable or unacceptable kinds of behaviours.

It would appear that the importance of understanding lay beliefs lies not only in that they contain distorted elements of scientific knowledge, but also that they may encourage people to misunderstand the risks that are associated with particular kinds of behaviour (Aggleton *et al*, 1989). On the one hand, the

concerns may stem from the recognition that lay beliefs, to a large extent undermine the desired effects of education and counselling objectives in advocating for safer sexual behaviour. On the other hand, they may serve to enhance communication and understanding between clinicians and their patients or clients.

1.7 POWER ISSUES IN DOCTOR-PATIENT RELATIONSHIPS

As part of the investigation into the understanding of explanations, the role played by the biomedical model has been studied, together with lay beliefs about illness and their implications for clinical and counselling objectives. The exchange between doctors and patients who have different worldviews about illness occurs in a particular power relationship. This relationship is determined to a large extent by doctors whose knowledge is based on exploring and quantifying aspects of a disease and those who experience illness. Theories on aspects of power within clinical settings are next considered, particularly those who deliver health services as well as those who receive them.

Kleinman (1983) argues that in any given health-care system where clinical realities differ or are in conflict, the sources that legitimise and empower the system ultimately determine which view prevails, and which clinical reality is sanctioned. Power becomes the determining factor in terms of constructing and perpetuating a particular kind of clinical reality and its culture. Clinical reality defines who the 'patient' or 'client' is in accordance with the language, norms and beliefs about illness that are part of health system's cognitive structure (Kleinman 1980). In South Africa, unequal relationships between clinical realities mirror other unequal relationships within the broader social context (Reynolds & Swartz, 1993).

It is also necessary to investigate another important facet of that relationship: the role and position of nurses and, in this case nurse-counsellors, within the hierarchy of health care.

In South Africa, counselling is largely carried out by nurses who are at the forefront of professional care-giving to the patients (Stein *et al*, 1994). They play a demanding and vital part in facilitating an efficient service between the doctor and the patient by assuming a number of roles demanded of them at any given time. Stein *et al* (1994), also argue that nurse-counsellors are in a pivotal position in the hospital system where they act as both gatekeepers and intermediaries between the patient and the doctor. Their position in health-care institution is strategic in that it makes it possible for them to clarify issues and enhance negotiation in doctor-patient relationships.

It is generally known that nurse counsellors in their professional training and practice assimilate certain beliefs about diseases, their aetiology and modes of treatment in a similar way to doctors. While it would be unwise to assume that they do not identify with certain aspects of the patients given the shared background, it can be assumed that they identify largely with doctors rather than clients on aspects of health care that are more similar to doctors rather than to their clients. However, in terms of the nurse-counsellors' position, various roles such as responsible health care workers, intermediaries of language and culture (Stein *et al*, 1994), professional nurses and educators, these roles can be contradictory at times. Given the skills and responsibilities demanded by each role, it may be assumed that they are in an ambiguous position at any given time.

The discussion examined the different ways in which doctors and their patients view illness, how their views employ different systems of proof, and assess the effectiveness of treatment (Kleinman, 1980). The role and position of the nurse-counsellors has reflected how power relations in health care mirror realities within the broader social context of the research question. The last part of the theoretical framework investigates people's explanations and meanings in order to make sense of their world and how this helps assert their positions within particular contexts.

1.8 THE FUNCTIONS AND MEANING OF EXPLANATIONS

Theoretical perspectives already discussed have led to ideas about the nature of explanations and the context in which they are used. The understanding of the meaning of explanations arose from concerns within and outside social psychology, where theorists called for people's accounts of their own actions as respectable research tools (Antaki, 1988). Through understanding their constructions and meaning of HIV/AIDS, the research questions may be answered as well as having implications for counselling.

Various theoretical frameworks have been examined which demonstrate the nature and different meanings of illness, the context in which they are used and the power that is vested in health care thus perpetuating unequal relationships between patients and healers. It would seem that the assumptions with regard to representations of HIV and AIDS follow a similar pattern for several reasons. HIV and AIDS are entities which are discoverable in nature and whose identity and construction were made known through scientific methods like many other diseases. Similarly, in the process of its discovery and construction, medical science enjoys a predominant and privileged position in relation to other forms of health care (Smith, 1991).

The other similarity is that HIV and AIDS have a subjective aspect. Both these are experienced in various ways: illness, shock, depression, fatigue, body pain, tiredness, weight loss and other symptoms. Because of this subjective experience, by different people of different cultural positions, the virus is assigned different names and meanings within particular systems of different cultures, such as medicine and traditional forms of healing. Although these constructs and meanings may be equally valid, they may not be equally correct.

Farmer (1992) argues that because AIDS is a discoverable entity, different concepts of AIDS change overtime; from a time when people knew very little about it to a point

where they draw on both biomedical and folk explanations. 'Sida' in Haiti is an example of how AIDS was experienced and led to several constructions and subsequent consensus about its aetiology, course and treatment (Helman, 1994). In Botswana, Helman (1994) reports that AIDS took on a folk meaning whose aetiology was associated with 'meila', a disease caused by breaking sexual taboos. He further argues that AIDS has become a 'preeminent folk illness of modern age whereby it absorbs aspects of local context, a variety of indigenous images, metaphors, and cultural themes. As it is in all forms of misfortune, these provide answers to questions that people ask themselves such as Why me? and Why? (p. 348)'.

The second argument of personal experience and meaning helps examine how people individually understand events. People are perceived as constructive thinkers who are constantly confronted by events and in search of explanations for the causes of such events (Jones, Kanouse, Kelley, Nisbett, Valins, Weiner, 1972). Explanations are largely determined by personal interests, emotional considerations and gains. They do not occur spontaneously (Jones *et al*, 1972).

Explanations also serve a function in people's daily lives and enable them to manage the world through the way they perceive life events (Potter & Wetherell, 1992). Mental representations develop over time and through a process of adaptation and assimilation, become internalised as forms of social reality as symbols, meanings and norms governing behaviour, perceptions of the world and interpersonal communication with others. They present the individual with ways of interacting with and ensuring continued control over the environment (Antaki, 1981b).

Representations also shape reality and determine its meaning. The meaning of the reality enables an understanding to interpret events. Reaction to events is a function of those events as presented, rather than by their actual situation (reality). What this means is that actions in any situation are determined by beliefs about that situation rather than the situation (reality) itself. It is the construction of the situation that constitute a barrier between people and reality. Constructs are a people's creation; they are changeable (Antaki, 1988).

The use of power is central to constructions. Individuals possess linguistic resources. This refers to their ability to use power and credibility in order to persuade others in talk (Potter *et al*, 1992). These methods are used creatively by individuals to monitor and construct situations and the way they are perceived by others. The motive for people's constructs to be dominant stems from the desire to enhance their own versions of events against competing versions of others' voices (Antaki, 1989). It is also to use power to enforce self expression through the narration of events. In constructing the self in one way, other constructions are made subordinate or become excluded; power relations become maintained within a context of domination and subordination of versions.

Because constructs guide the way in which meaning of the world is derived, they often help substitute what cannot be seen, heard or felt. In that way, they tend to have less accurate representations of situations and events (Antaki, 1981). Constructs help sort out actions or sequence of events in the world within the parameters that are laid down by society. This implies that people exercise power within boundaries that are approved by society (Edwards & Potter, 1992).

Antaki (1981) also offers an understanding of how people assert their power by processing information about possible causes, course and outcome of events or when confronted with ambiguous situations. They will use unconscious or automatic explanations that have been internalised or stored over the years which represent tools to process old and incoming information (Antaki, 1988). In that way, the ambiguity and diversity of life become minimised. They choose causes, locate required effects and incorporate events in the context of a system of relationships with other events and people and thus reconstruct meaning out of events (Edwards *et al*, 1992).

1.9 SUMMARY

This chapter commenced by exploring developments and explanations since the first cases of HIV and AIDS were reported. The background, a history of HIV and AIDS, was discussed with patterns of infection worldwide and locally. This provided a framework for understanding the developments that have taken place and also contextualised counselling as a crucial strategy in preventing the disease. The discussion also situated counsellors within the context of AIDS health care, and examined scenarios in which counselling takes place in South Africa.

To further understanding of how counsellors and their clients understand and explain HIV and AIDS, theorists from medical anthropology outline the role of culture in aspects of health care such as illness and disease and how it varies, particularly between those who deliver services and those who receive them. This understanding was furthered by views on how knowledge and power are developed and entrenched within modern medicine and how they determine caregiving. This investigation laid a basis for conceptual frameworks on explanations, explanatory models, theories of illness and, more particularly, of HIV/AIDS as specific to the research question. The discussion of aspects of power in clinical settings helped illustrate the role and position of the (nurse) counsellors in health-care systems, and their relationship with doctors and clients.

The last section explored the ways in which people understand and analyze causes of events, how these help them arrive at conclusions and how the conclusions affect their behaviour. People are perceived to be constructive thinkers, constantly manoeuvring appropriate information in order to exercise continued power and control over their environment.

The framework for understanding and exploring the various aspects of the study will be used to analyze issues and themes emanating from counsellors' and clients' explanations

of HIV and AIDS. These issues illustrate the meanings that are derived from the constructive use of language to assert power and control. This will, in turn, provide a framework for a discussion of the way in which these factors affect counselling objectives.

CHAPTER TWO : RESEARCH METHODOLOGY

2.1 BACKGROUND TO THE STUDY

HIV/AIDS counsellors fulfil a variety of roles such as educating an increasing number of patients as well as other people on aspects of HIV and AIDS. They are required to apply various strategies aimed at curbing unsafe sexual practices, facilitating understanding, management and providing support to those in need. They are also called upon to empower patients to come to terms with a highly stigmatised disease which not only threatens physical health but every aspect of a person's existence from primary relationships to economic survival (Stein *et al*, 1994).

The study was undertaken to investigate counsellors' and clients' explanations of HIV and AIDS in Cape Town and the surrounding areas. It elicits explanatory models of illness of the two sets of participants, the ways in which they use their respective constructions to explain HIV and AIDS and the implications for counselling objectives.

The literature review has provided a broad framework which can serve as a basis for an empirical exploration of the research question. This framework provides an analysis of clients' and counsellors' explanations of HIV transmission and AIDS. Five fundamental questions are examined to clarify the objectives of the study:

1. What kinds of explanations predominate in the narratives amongst the two groups of counsellors and clients?
2. Are there differences in the two groups of participants in their explanations of HIV and AIDS?

3. How can these explanations be understood within a framework of cultural meaning?
4. What functions are served by these explanations?
5. What are the implications of the kinds of explanations used by each for effective counselling?

These questions are linked to one another and can be used as a basis to explore the various themes that emanated from the narratives of the two groups of respondents and the likely effectiveness of counselling in terms of its objectives. As far as this research is concerned, it is within this framework of cultural meaning that we are able to examine the participants' explanations of HIV/AIDS; its aetiology, progression, treatment and prognosis.

This research question is formulated within the framework of a qualitative methodology. Qualitative methods are loosely defined by Parker (forthcoming) as a method of interpreting a particular issue or problem. The researcher becomes central to the meaning that is made of the problem. The selected domain of interest becomes the focus of action and experience. Maxwell (1992) argues that qualitative methods recognise that analysing people's accounts involves vast and complex material. Therefore, the exploration and analysis should lend itself to contradictions and gaps of which the researcher is an inherent component.

2.2 THE SAMPLE

The study utilises an 'accidental' sample (Kerlinger, 1986) the people comprising five counsellors and five clients. For the counsellors, the basic criterion was the completion of

the ATTIC AIDS Awareness Course, as well as direct involvement in counselling people with HIV or AIDS. The sampling uses available respondents. In terms of representativeness, it is arguably the weakest form of sampling and caution should be exercised in the analysis and interpretation of data (Kerlinger, 1986).

One reason for choosing this kind of sampling related to the difficulty the researcher had in selecting counsellors who met the required criteria. Among the professional nurses who had done the counselling course, some were not involved in counselling while others were, but due to the workload or some other reason, were unable to render this service and therefore needed to refer to other places.

The second reason was that there were those who had not done the course but were engaged in counselling on account of their interest in HIV/AIDS or because there were no others trained to do so. It should be noted that for the type of this research, the aim is to observe, analyze and describe what is happening rather than generalise on the findings emanating from the data.

All ten participants in this study are African and Xhosa-speaking. They were accessed as counsellor-client pairs from various health centres such as Gugulethu 1-1; Somerset Hospital 1-1 and Khayelitsha 3-3. One important aspect for exploring this area is that counsellors as health providers undertake more than one role such as translators and intermediaries of culture. They also link doctors and patients (Stein *et al*, 1994). It is argued that counsellors, because of the common background they share with patients, understand most aspects of the patient's life.

All counsellors selected for the research were involved in HIV and AIDS counselling. The sample, therefore, consisted of people with direct experience of AIDS counselling. It is important to emphasize that this was not a homogeneous sample of HIV/AIDS

counsellors but a sample of community workers and professional nurses working in this field. The clients had been counselled for more than two sessions.

Two of the counsellors were trained community workers (CWs) and were based at Somerset Hospital and Gugulethu clinic respectively. They were involved in HIV/AIDS and sexually transmitted disease (STDs) counselling and health education. The other three participants were professional nurses (PNs) based at three Regional Services Council clinics in Khayelitsha. The interviews for the two counsellor-client pairs were conducted at Gugulethu Clinic while three were held in Khayelitsha; two of these at Nolungile Site C clinic; and one at Harare/Empilisweni Clinic. For the PNs, two interviews were conducted at Nolungile Site C clinic and one at Harare Empilisweni Clinic.

The second sample consisted of five clients. They had been diagnosed with HIV/AIDS and were attending health centres for a minimum of three months. They had formed a relationship with the counsellors. All the clients who were interviewed had been diagnosed through an AIDS-related illness or infection. They had at least, one contact with a major provincial hospital such as Groote Schuur, Somerset or Tygerberg and had been referred to a local hospital or clinic for further management. Three clients were being treated for TB; one for swollen lymph glands and while the third had a skin rash.

In terms of gender, three clients were male while two were female. Of the two females, one had a baby also diagnosed with HIV/AIDS. All the counsellors were female. All the PNs attend support-supervision sessions with a psychologist at Lentegeur Hospital on a monthly basis. The researcher made arrangements with the psychologist, the PNs themselves and the heads of their respective departments to attend. The researcher introduced herself and the research to the PNs. Individual members who fitted the criteria gave permission to participate. Individual interviews were first arranged with the PNs and

later with the clients. The CWs were approached after permission was granted by the head of the HIV unit at Somerset Hospital.

In order to investigate shared or unshared cultural explanations, the counsellors and clients were selected as matched pairs; each counsellor provided counselling to a client in the sample.

2.3 INTERVIEWS

The participants' explanations were elicited from an interview schedule. The interview schedule incorporated questions developed by Kleinman (1980, p.104-118) to elicit explanatory models about illness. Data was collected by audio-tape. Open-ended questions were used to gather identifying or demographic information and to elicit information about the respondents' explanations of the nature of HIV/AIDS. Open ended questions are generally useful in interviews because they help establish rapport with the respondents. They enable respondents to talk about specific experiences, behaviours, thoughts and feelings rather than closed questions which are known to limit responses (Egan, 1990).

The interviews were aimed at eliciting participants' explanations of transmission, aetiology, symptoms, course treatment and prognosis of the disease. The last section of the questionnaire elicited information about the respondents' understanding of the counselling role and experience. The researcher used probes in order to help clarify point or to encourage the respondents to elaborate, and to develop particular themes. Counsellors' interviews and responses were predominantly in English while those of the clients were conducted in Xhosa.

2.4 DATA ANALYSIS

This section discusses briefly the kind of research method that will be used as a basis to explore and analyze the research material. The difference between qualitative and quantitative methods in social sciences has been much debated, with regard to whether they are philosophical or methodological. On a philosophical level, it is argued that quantitative analysis adopts the view that events are always subject to causal laws and can therefore only be studied through a scientific method of classification and quantification (Mwale & Burnard, 1992).

Qualitative research on the other hand offers a means of studying people's beliefs and meanings. It aims to capture the essence of explanations; to explore and systematise the significance of people's beliefs about phenomena (Parker, forthcoming). While it has been criticised for its limitations in terms of validity and reliability, it has its premise that all meaning is indexical in that meaning will always change as situations change (Maxwell, 1992). In summary, this research aims to explore the counsellors' and clients' explanations of HIV and AIDS and the functions that they serve through qualitative methodology that allows for the participants ideas to emerge from the data.

Counsellors' interviews were transcribed from the audiotape. Clients' narratives, however, needed first to be translated. This process was time-consuming and arduous because the researcher had to filter manually through the material several times in an attempt to portray the meaning in a way that resembled those of the participants without reducing or simplifying their content.

The first difficulty was in the translating the clients' narratives from Xhosa into English. Although the researcher is fluent in both languages, there were several difficulties. Firstly, it was difficult to portray the emotional, social and cultural meanings of the narratives from one language to the other in their entirety. Secondly, translating words

which had their own meaning in Xhosa but no equivalent meaning in English proved very difficult. Thirdly, the shared cultural background of the researcher with patients, her psychological orientation and research role demanded constant awareness of and shifts between these complex conceptual frameworks while articulating the meanings of explanations. As Banks (1991) argues, when there is an exchange between two languages, this cannot be neutral or decontextualised but a process where all the stakeholders are affected and in turn affect the process.

2.4.1 Method of Data Analysis

Qualitative methods were used to highlight the explanations used by the two sets of participants. Antaki (1981b), suggests a process whereby the understanding of explanations operates within a framework that makes use of meaning by using key terms or concepts. This restriction (Edwards *et al*, 1992) helps manage a range of diverse natural responses by counting them as data without oversimplifying or reducing or losing the texture and meaning of the findings (Potter *et al*, 1992). The specific themes and patterns that arise between the constructions of the two samples are compared and analyzed for consistency and variability.

The first level of the analysis involved detailed qualitative analyses of data in grounded theory style using an explanatory model framework. This qualitative analysis relied on a deductive approach to explore what is happening in the given situation (Glaser & Strauss, 1967). In this kind of research, the researcher 'immerses himself' in the social world and 'allows himself to discover what is there' (Burnard, 1992, page 89). Following this exploration, a theory is then developed.

The explanatory model framework is a useful tool in providing a means of exploring participants' understanding of the condition. It also provides for investigating microlevel changes in people's understanding cross-culturally and across ethnic groups (Kleinman, 1980). These methods were used to illustrate and analyze in depth the differences and

similarities between the counsellors' and clients' explanations on various aspects of the HIV/AIDS, their understanding of aetiology, the course as well as treatment and prognosis of the condition. It also provides for investigating microlevel changes in people's understanding cross-culturally and across ethnic groups (Kleinman, 1980).

The second part of the analysis used an in-depth qualitative analysis of counsellor-client case study in a manner consistent with grounded theory. This focused on the meaning and function of explanations and how the respondents controlled and maintained power in talk.

The diagram below illustrates the two levels of analysis which will illustrate the analysis of findings.

| | |
|-----------|--|
| 1st level | Qualitative analysis of themes using explanatory models in grounded theory style |
| 2nd level | An analysis of a counsellor-client case study |

2.5 REFLEXIVITY

The researcher's role, beliefs and theories in the research process cannot be ignored. The researcher's work and involvement in the HIV/AIDS area may also be a determining factor in the way in which narratives are expressed by the respondents. Secondly, in the process of 'immersing' oneself in describing and translating accounts (Burnard, 1992, page 89), the researcher may distort reality because accounts are a means to making sense of the world and formulating questions (Potter *et al*, 1992). Descriptions do more than merely describe. They explain more in a social situation than merely reporting facts (Schwartz & Jacobs, 1979). In discourse, therefore, to be transparent is worthwhile and

acknowledge how one's language constructs a view of the world and go on with the analysis of the content material (Potter *et al*, 1992).

2.6 RELIABILITY AND VALIDITY

Antaki (1981b) has made some suggestions with regard to establishing reliability and validity. An individual account cannot represent a reliable representation of the situation. The accounts of all the participants and their views including those of the researcher should be integrated. It is recognised that people who are involved in observing and interpreting the world are inextricably part of it and, cannot, therefore, claim to experience these objectively (Parker, forthcoming).

Difficulties arise out of the subjectivity of researcher and qualitative nature of the study. These are recognised as an essential part of analysing explanations, and help in exploring a range of explanations as well as options for future use (Potter *et al*, 1992; Parker (forthcoming). It is important to recognise that validity in qualitative research refers to accounts not to data or method; validity is therefore relative to the purposes, circumstances of accounts, and the inferences drawn from them (Maxwell, 1992).

CHAPTER THREE : FINDINGS

The findings are presented as follows :

In this chapter, a qualitative analysis of themes using explanatory models is discussed. Chapter 4, will reflect an analysis of a case study of matched counsellor-client pair and in Chapter 5, a summary analysis, recommendations will conclude the study.

IDENTIFYING DEMOGRAPHIC CHARACTERISTICS

The demographic details of the five counsellors and five clients are illustrated in Table 3.1.

| Demographic Char. | Counsellors | Clients |
|---------------------|-------------|---------|
| Age Range | 38 - 45 | 23 - 43 |
| <u>Gender</u> | | |
| Female | 5 | 2 |
| Male | 0 | 3 |
| <u>Employment</u> | | |
| Fulltime | 5 | 1 |
| Unemployed | 0 | 2 |
| Disability | 0 | 2 |
| <u>Education</u> | | |
| Std 6 and below | 0 | 5 |
| Matric+ | 2 | 0 |
| Professional nurse+ | 3 | 0 |

Demographic characteristics are illustrated according to the respondents' age range, gender, employment and educational qualifications. The counsellors' ages ranged between 38 and 45 while the clients' ranged between 23 and 43 years. In terms of gender, all the counsellors were female while there were three male and two female clients. One of the female clients had a baby diagnosed with HIV and was receiving TB treatment.

All the counsellors and one client were in full time employment; two clients were unemployed and the remaining two were on disability grants. In terms of education, two counsellors had matric as well as having done some courses in paralegal work. Three counsellors were qualified professional nurses. The counsellors had all completed the HIV/AIDS counselling course. The clients' qualifications were all below standard 6.

3.1. QUALITATIVE ANALYSIS OF THEMES USING EXPLANATORY MODELS

The first level of the analysis is a qualitative analysis of the counsellors' and clients' narratives. This is used to illustrate and explore in depth the differences and similarities of the participants' explanations of HIV and AIDS including their understanding of:

- (a) aetiology
- (b) the course of illness
- (c) the treatment and prognosis
- (d) counselling experience

These categories were drawn from the interview material in a manner consistent with grounded theory.

3.2 AETIOLOGY

Helman (1994) argues that the aetiology of illnesses and diseases are multicausal in nature, and a variety of causes may act together at a particular time. According to him, the aetiology of illness may be seen to lie within one of four domains: the patient, the

natural world, the social world or the supernatural world. The degree of elaboration in the aetiology of illness varies depending on a number of factors such as education, knowledge of traditional medicine and/or biomedicine (Pool, 1994).

The causes may fall into several categories incorporating those events that occur prior to onset, actions of the particular individual or of another person, the physical environment or a medical disease and its presumed biomedical basis. Human beings provide a wide range of explanations and most of these comprise a cluster of factors which are loosely linked or unrelated, or even contradictory. These factors may be borrowed from different health-care systems, such as the popular, the folk and the professional sectors (Helman, 1994). For this research, the counsellors' and clients' explanations of the aetiology of HIV/AIDS will be discussed under four headings:-

- the mode of transmission
- populations at risk
- the natural and the social world.

Mode of transmission

From the interview material, it would appear that counsellors (n=5) used predominantly medical explanations to describe the mode of transmission of HIV and AIDS. Transmission was reported to occur through 'body fluids' such as semen, blood and breast milk.

The primary mode of transmission identified was through semen during sexual intercourse where HIV is passed from one 'infected' person another. Transmission in this case, occurs when the infected person passes on the virus through unprotected sexual intercourse (without using a condom) to an infected partner.

Infection through blood was identified by all the counsellors. Some mechanisms were shared while others varied. The ways in which infection occurs was through 'blood transfusion' (n=4), through open wounds or cuts (n=5) and 'cutting customs' in circumcision and tribal cuttings when the same instrument is utilised on a number of people without being sterilised (n=2). Infection from a mother is passed to an unborn baby during birth through the 'umbilical cord connection' (n=2) where blood may be passed to the baby. Infection through anal sex occurs when the 'rectum walls rupture during penetration'. The sharing of sex toys and unsterilised needles with infected people was also mentioned (n=1). 'Deep kissing' and oral sex with 'open sores' was reported to carry 'some risk'(n=1). The basic mechanism reported was that infection occurs through blood when and if it is transmitted from a person with AIDS. The virus is transmitted freely into the blood stream through these modes of transmission.

The third mode of transmission identified by the counsellors (n=2) was through a mother feeding a baby. However, the mechanisms of transmission were unclear.

... although I am not sure of the literature, the person at the seminar said that it was proven that there were babies who were born to infected mothers, but when they started to breast feed, they got AIDS.

Clients (n=5) similarly reported transmission through sexual intercourse and blood to be the main ways in which the disease is contracted. Common aetiological explanations about sexual intercourse were when 'a man sleeps with a woman'; 'a woman sleeps with a man'; 'a man sleeps with another man'; when 'two women sleep together'. AIDS was reported to be transmitted when the male partner infects the female partner who is not infected, by 'pouring it' and it 'travels within the blood'. The degree of elaboration, however, was limited in terms of the medical explanation in comparison to the counsellors' explanations. Clients reported that they were 'told' of these explanations by the counsellors. Secondly, clients (n=2) identified transmission as occurring to them in a much more active and intentional process than is implied by medical explanations. Client 5 for example reported,

I have 'idliso'¹. It was put inside my body by the witches; they use tricks when you are sleeping ...

and client 3 who did not believe that the disease could be transmitted reported,

... I am not the first person to have idliso which portrays itself as TB. Idliso is not infectious, if it's meant for you, it's yours and a person can never get it from you...

Clients (n=3) reported that infection through blood occurred when an infected person has a cut. Client 2 reported that if there is bleeding, a person may become infected if not 'protected with gloves', whereas for client 1,

when you are using a blade, you should not use somebody else's blade who has this disease because they say that if your blood comes into contact with the blade and I give it to you and you also shave with it, and cut yourself, then with your blood and mine, you will get it.

Client 4 reported a similar explanation but added that transmission could also occur through insect bites,

You have a cut and you do not bandage it and you have blood and you hold another person without covering it and when maybe there is a mosquito, it draws blood from you I think one can get infected that way too.

What emerges on the one hand is that the modes of transmission are quite similar for both groups with one exception. On the other hand, there was a qualitative difference in the manner of explanation. Firstly, counsellors' explanations are predominantly objective while those of the clients are concrete. Counsellors' medical explanations are more elaborate than those of clients. There is some intention (human or supernatural) implied in clients' explanations, while counsellors accounted for the transmission far more neutrally in terms of the anatomical or bodily processes.

Populations at risk

Populations at risk were identified by the counsellors as those individuals or groups who were perceived to be vulnerable through their activities, sexual orientation, and origin or residence. Counsellors also tended to pathologise these populations as a group whose behaviour was an inherent part of their nature, as 'confused' and 'having problems'. The same were identified by the clients as having acquired the disease through their actions and those of others or failing to protect themselves from those who were perceived to be potential carriers.

Counsellors (n=5) identified certain actions by kinds of people as determinants of whether or not they acquire HIV. For counsellor 4, HIV/AIDS occurs in

men who have a problem and approach other men for sex and end up sleep with each other.

According to counsellor 2,

... people do not want to agree that they are promiscuous, are confused with witchcraft change partners not knowing that they are open to reinfection ...

Counsellor 5 suggested that,

people engaging with more than one sexual partner, those who are promiscuous ; those who have many girlfriends and those who sleep around with whoever are easily infected.

All the clients (n=5) used explanations relating to themselves of having acquired the disease through their actions with 'others'. Some of the 'others' were perceived to be potential carriers. Of particular importance was the clients' emphasis on the role that they played through their own actions with others with whom they engaged in sexual acts,

I am a drinking person and the person that I was seeing was sleeping around ... according to my understanding, on the few days that I did not get her, it is likely that she might not have slept with one man and I got infected.

For client 2, the disease is linked with a particular set of people and this makes AIDS a disease which defines people in terms of those who are diseased and those who are vulnerable,

I got this by sleeping with those truck people and I started seeing them in 1984. I heard about it on wireless' and I thought I must have this thing. When I was told, I was expecting it... I thought this disease is brought by the truck people ... that this dirty blood it's a new thing, brought by them.

However, client 3's explanation seems to imply a link between the timing of a recent sexual activity, and onset of illness and geographic origin of partners as determinants for risk of infection,

at the time that I was sick I was almost two months without a woman. I taught myself to have self control. I do not love one person today and another person tomorrow. I once had a girlfriend in Durban and another one in Johannesburg. All of them were ordinary people staying in the township.

It appears again that there were qualitative differences and similarities in the way that counsellors and clients perceived those who are at risk. Counsellors identified populations that are at risk by using as determinants sexual orientation and promiscuity or personal characteristics with a strong element of pathologisation. Clients on the other hand, regarded their infection as caused by their own, often unwilling actions. They associated factors such as occupation and place of origin with risk. Both the counsellors and clients perceived involvement with multiple sexual partners as a risk factor.

HIV/AIDS as originating from the natural world

Clients (n=3) and one counsellor perceived AIDS as originating from the natural world, where the disease is 'caught' from or found in the environment. This created confusion in how clients accounted for their positive HIV status but also implied that this disease was contracted from outside or was something that people brought in from other places.

Counsellor 4 maintained that,

we differ ... while there are those who have naturally wrong immune systems, there are also those who catch all the passing disease and are not immune to every disease that comes across.

For client 3

... I am told that this disease is something that is around ... I have also heard that this thing is like ubhubhane. (plague)

Client 5's statement implied that AIDS is something that may be acquired within a certain environment or from other places rather than one's own neighbourhood,

... I was shocked and surprised about AIDS because this person that I am in love with has never gone to any other place ever since we were together.

What emerges from these statements is similar to the explanation of counsellors and some clients; that is, that AIDS originates from the natural world, as a destructive force which is inherent in the environment. The difference, however, is that other clients reported AIDS as a disease that can be found in particular geographic areas other than one's own.

AIDS as originating from the supernatural world

This explanation by clients (n=2) was not shared by the counsellors. It was reported that AIDS originates from evil intentions or witchcraft. Client 5 reported,

I know that I have 'idliso' ... it was put inside my body by the witches, they use tricks when you are sleeping. It makes it very difficult for me to eat and swallow because it is smoking thus leading to swollen lungs, itchy throat and difficult breathing.

Client 3 also perceived intention and disinfection as central to the origins of idliso. These served to invalidate the infectious component of HIV/AIDS, the medical explanation and thus his diagnosis,

... idliso, unlike this thing, is not infectious, if it's meant for you, it's yours and a person can never get it from you..

From the above comments, it appears that, unlike counsellors, clients perceived the causes of HIV and AIDS, amongst other things, to originate from the supernatural world such as evil intentions and witchcraft by others.

3.3 NATURE AND COURSE

A number of factors were identified by the counsellors (n=5) as important determinants in the progression of the disease. These included the immune system, stress, social and economic circumstances, lifestyle and knowledge of diagnosis.

Counsellors reported the nature and functioning of the immune system, its relation to HIV/AIDS progression and how to maintain a healthy lifestyle as important factors. These views were based on their own experience as well as information acquired from training. The clients' descriptions of the course of the disease focused on activities that should not be engaged in and their consequences. Clients (n=5) explained physiological changes and gradual deterioration of the health (immune system) according to their life experiences.

Lifestyle, immune system, and disease progression

Counsellors (n=4) reported 'the patient's lifestyle', 'immune system' or 'immunity' as determinants in the progression of the disease. Whether or not the factors were predisposing, precipitating or consequent factors could not be established. These were the responses from the counsellors:

People with multiple sex partners or promiscuous would be easily infected because they do not want to agree that they are promiscuous. (counsellor 1)

it depends on the lifestyle and also the immunity of the person ... some people become infected this year and they die before the end of the year, with others, it can take 15 to 20 years for the person to last. (counsellor 5)

Apart from the immune system, counsellor 5 perceived the body condition with regard to health, strength and make-up also to be a factor

is it not the person's immunity. For some it is strong while for others, it is weak. Our constitution differs, you see.

For the clients (n=3), the rate of progression of the disease was linked to certain actions or guidelines that they needed to follow. If these were not followed, this could result in early death. These were the responses:

In that meeting, they told us that when you do not abstain from sex, it penetrates your body faster and you pass away sooner (client 1).

the nurse told me to use a condom and that you, must not have many boyfriends... (client 4).

However, the client was unable to give reasons for these particular actions.

For client 3, explanations of a very specific and concrete nature reflecting disease progression were reported,

certain things called soldiers which guard the body and that this thing targets these soldiers and eats them and when they get depleted, then the disease affect you easily because there is nothing that protects you. The result of this may be that you will have a sore or wound that does not heal because there is nothing to replace those cells that have been destroyed.

What emerges from the above is that factors such as lifestyle, promiscuity and a compromised immune system were seen by the counsellors as determinants in the rate of disease progression. Clients, on the other hand, emphasised particular actions that 'should not' be engaged in. There was also a qualitative difference in the concrete manner in which clients described how the body's immune system is invaded. Common themes identified by both groups included practising unsafe sex and sexual intercourse with multiple partners.

Stress, social and economic circumstances

Apart from the person's immune system and lifestyle, both counsellors (n=3) and clients (n=2) named stress resulting from economic and social conditions to be a complicating factor,

it depends on the person's immune system ... how they look after themselves, their lifestyle and their diet. With a diagnosed person, if I can use my common knowledge, like when the person is anxious. I am sure a mother with children, the duration would be shorter, more especially if she has kids and is anxious about them. (counsellor 1)

From counsellor 2's experience, it seemed as if in addition to the fact that clients are compromised by their social and economic circumstances, they also find it difficult to cope and live with a positive diagnosis,

... if you look at our people in the township, who are underprivileged and poor, what comes first... you can see that the person is worried about children, money, food. Those are the people whose diagnosis, I find, has destroyed their lives and on top the epidemic itself because of the social problems.

Clients reported similar concerns, as well as the effects of the progression of their ill-health on their personal, social and economic circumstances,

I was released from work because of irregular attendance and sickness. I was unable to apply myself to physical duties and also in dusty areas because of my chest. I had to see a doctor daily or sometimes weekly. I even ran out of money to pay the doctor. (client 5)

For client 2, the progression was a subjective, physiological and active process over which she had no control. This was made difficult by the unfavourable social and economic circumstances,

... it is a funny disease because when you are hungry, you may even faint, you can't wait for food to cook. It is as if something's digging you inside. Even though I am getting a disability grant, it's not enough... I've got accounts for meat, because when you have this disease you don't like any food without fat ... (client 2)

It would seem that there were both qualitative differences and similarities in the way both counsellors and clients described their understanding of the factors that play a role in the

course of illness. While counsellors reported stress, social and economic factors as determinants, clients tended to describe these in terms of their own experience of pain, ill health and basic needs which could not be met due to economic circumstances.

Knowledge and effects of diagnosis

Knowledge of the diagnosis was seen to have an indirect effect on the progression of the disease by both the counsellors (n=3) and their clients (n=4). However, perceptions about this varied. For counsellor 2, knowledge of diagnosis could unleash emotional reactions which undermined the counselling objective of preventing psychological distress. Emotional reactions may prevent them from taking control of their lives and managing their lifestyle in a way that would prolong their lives. It seemed that both of these were drawn from experience and 'common knowledge',

once people get diagnosed HIV+, they often do things that they would not normally do. They will drink more than necessary, they will not exercise, will smoke or start drinking because of anger ... I know of a person who was diagnosed in the beginning of the month and died at month end because of delayed shock and he ended up having diarrhoea ... because of stress he did not have when he was not aware. (counsellor 2)

... I do not think I have the knowledge with regard to a diagnosed person, but if I can use my common knowledge, like when a person is anxious, I am sure a mother with children, the duration would be shorter ... With a male, it might be shorter, ... because he will say all these things have already happened to me, let me go and mess around. That would shorten his lifespan, he may start abusing alcohol, not eating and angry than with a person who does not know and has no worry about it. (counsellor 1)

Not all clients reacted with worry to a positive diagnosis. It seemed as if there was a category of people who reacted in a way that was baffling to the counsellors. The implication of positive diagnosis in terms of the progression of the disease was unclear.

For example counsellor 4 reported,

... people who are do not 'understand/not city wise' are often surprised when you call them into the kamer. You will find that when you sit down with them, they are not particularly concerned with keeping it secret, but were told so... they will go knocking on all doors asking 'where's the AIDS nurse because I've got AIDS'. Others, you can see that, shame, they understand and they will try to hide themselves.

For clients, it appeared that even before testing, knowledge of a diagnosis prompted distress and this reaction led to resistance to consent for a blood test. It seemed that having a positive diagnosis would not only be stressful but also stigmatising and difficult to live with,

... if you are not going to cure me, what are you going to do about the blood? And when you find this thing, which I usually hear that people don't last for three years, so you want me to sit with worry that in such and such a year, I will die or before that ...

Because clients often encounter different reactions from people in their social environment and in health-care centres, it becomes difficult to escape feeling alienated, different and stigmatised. This appears to develop into a disease of difference,

... when you hear of your diagnosis, you are faced with difficulty because you cannot even tell your neighbour that you have this thing because it will spread all over Gugulethu and people will point fingers saying 'that one is like this and this ...

... if there is an old and a new nurse, and they call you in to see the doctor, you will see the old one nudging the new one, you can see when coloured people are talking about you- you also have your own conscience eating you and you think that they are talking about you and you hear that 'shame'... (client 2)

Counsellors' emergent themes reflect clients' knowledge and reactions to a positive diagnosis as factors which undermine counselling objectives. They contribute to psychological distress and not towards managing a healthy lifestyle. At the same time, clients reported a positive diagnosis as a concern. They reported fear of a reduced lifespan, impending death, stigma and being alienated by others.

Symptoms associated with the disease

Both similarities and differences were reflected in the way that counsellors and their clients described the symptoms. Similarities which were experienced by the clients were mentioned earlier during counselling. Differences in the description or identification of symptoms by each group were evident. While counsellors predominantly used medical

explanations in an objective way, clients made use of subjective experiences in their description of illness.

Symptoms and diseases identified by the counsellors (n=5) were persistent pneumonia, diarrhoea, swollen lymph glands, unexplained weight loss, night sweats and skin cancer. Meanwhile skin rash, bleeding gums, fever and body sores were identified by three counsellors. Counsellors (n=4), also reported that these symptoms were similar to ordinary ailments and regarded 'recurrence' or 'persistence despite treatment' as a cause for concern and a determinant for HIV pretest counselling and testing.

Clients, on the other hand (n=5), gave accounts of their symptoms in terms of subjective experiences. Some (n=2) presented the illness in a way that indicated their idiosyncratic understanding of anatomy, the location of the internal organs and the inner functioning of the body, often emphasizing bodily experiences in terms of the diseased organ or part thereof:

I experienced a vein inside my head (I had a headache), 'my eyes became black' (my vision darkened). I had something hard here (pointing to chest) which made it difficult for me to swallow food.

I have idliso which was inserted by the witches and... my stomach feels hard and makes it difficult for me to eat and swallow ... now it is emitting vapour/smoking like when something is boiling.... my lungs are swollen, my throat feels itchy because the vapour/smoke comes into contact with it. I have pneumonia because idliso is boiling' and it makes my breathing difficult because of the vapour/smoke that it emits'. Now I have noticed that it is bursting/rupturing ... it comes out of my throat through my mouth dirty phlegm comes out when I induce vomiting.

Client 4, whose baby was also diagnosed HIV positive, explained similar symptoms. It appeared as if blood symbolised undesirable physiological problems such as fatigue and weight loss. The problems were associated with and confirmed some of the information received during counselling,

... even in my body, I could see that it was not like before.... there were no funny things before, I was healthy and plump, my skin was clear. I had no pimples like now. I could see as months went by that my blood had weakened (I had lost weight). I think what I see now resembles what they told me ... I am not the same person that I was I am not in good blood and my bones and joints have fallen (my

limbs feel very weak). The baby is also not in good blood, has poor appetite and cries every night when asleep ...

However, in spite of the fact that client 3 could reconcile the physiological changes and symptoms experienced with the biomedical explanations of HIV/AIDS obtained during counselling, this did not necessarily mean acceptance of the biomedical diagnosis,

I wanted to know these from the sister ... because I know that when I have fever, I cough and my nose becomes blocked ... I did not get anything substantial except that I will sweat at night and I was sweating a lot ... that I will get thin and I was very thin, I weighed 50kg at the time, I was sweating and often felt cold. I also lost appetite. I think these are the only things that she mentioned and I was experiencing them all at the time....but then my hope and heart were telling me that it was possible for me to loose weight because I was sick. The TB, I knew it was not really TB but idliso.'

Client 1 attributed the origins of physiological symptoms to active processes and personal intention by others in the social environment,

... since I'm wearing light clothes and talking to you and feeling alright, then I feel hot with sweat running down my back as if there is somebody who is working you and making sweat. You bath but instead of feeling fresh you feel tired as if you did not have a bath.

The emergent themes in the counsellors' and clients' explanations were both similar and different. Similar themes were particularly evident in symptoms that both groups had discussed during counselling which were experienced by clients. Differences were reflected in the way clients described their location of organs, physiological processes and symbolic meaning of these, including body parts such as blood and bones. There seemed to be a distinction between recognising certain symptoms and quite varying explanations of the underlying processes which gave rise to them.

3.4 TREATMENT AND PROGNOSIS

This part of the study investigated the respondents' perceptions of the nature, beliefs and effects of treatment and prognosis. For the counsellors (n=5), explanations of the aspects

of treatment were narrated in accordance with what they had learnt from the course, as well as their experience with patients. Both these examples were largely medical. Clients tended to give a wider repertoire of explanations and used various discourses drawn from different sectors.

Nature and mode of treatment

Counsellors (n=5) viewed the disease as 'incurable', resulting in the death of the infected person. Although people are treated for 'opportunistic diseases', this was reported to be a short-term solution. Counsellor 5 reported,

a drug called AZT which can only be afforded by a few, but this does not cure it only delays the onset of the symptoms of AIDS.

Counsellors reported a progressive deterioration of the body characterised by physiological and emotional changes. These respond to treatment initially but later become resistant to it. As counsellor 1 mentioned,

it is incurable ... the diseases that the person often presents with are treated ... like when the person presents with enlarged or swollen lymph glands and is given treatment, one can get better, but you meet them after some time, you can see that the person has many fears and he is getting worse.

On the other hand, the clients' understanding of the nature and mode of treatment illustrated a wide range of responses with two expressing a preference for 'medicines from Somerset Hospital'. They reported that they felt their condition was understood better than at day hospitals and that the day hospitals cost money in terms of travelling. Client 2 reported,

I want Somerset to give me permission to get that treatment at the day hospital.

Some were clear about the nature of the treatment and its intended effects. This seemed to encourage regular use,

I was taking about 8 tablets per day. When I was going away on a trip or leaving Cape Town, I would take a months supply. I took them regularly. It will take some time to get

used to going without them. There are five identical ones for TB and two for the appetite and one I didn't know for what, it's small and white.

On the other hand, there were those (n=3) who, in spite of biomedical forms of treatment, considered other modes of treatment as options. For example client 4 reported,

... there are no medicines to cure it, but I am told that there are people of isiXhosa who cure it. No one has told me how they do it with Xhosa medicine, but you pay R200 for it to be cured.

Client 5 reported using traditional medicines after using pills for a long time without improvement.

I use both treatments.... eintlik, I can say that I have used these pills for a long time with no visible improvement before I went to the 'person'...²

From the above, it appears that counsellors perceive the treatment as medical and aimed at alleviating presenting symptoms and opportunistic diseases, while clients reported preference for either medical treatment or traditional healing or both as modes of intervention. It also seemed as if in some cases, these choices were made as a result of effectiveness or perceived lack of it. The understanding of the intended effects of treatment seemed to encourage regular use irrespective of whether the treatment was medical or traditional.

Beliefs about treatment

It is worth noting that counsellors (n=5) believed in the medical treatment while clients saw traditional, spiritual and other forms of healing as appropriate and alternative modes of treatment and healing. Amongst the counsellors' explanations of their beliefs about treatment, counsellor 3 distinguished between the different sectors of health care and recommended a holistic approach,

everything in Western culture should be done in a test tube ... our people are shown visions while they are asleep. like 'go and mix this and that and cure. Our knowledge has been oppressed as is the case with our political history and this was labelled heathenhood indicates that drugs can only be prescribed by the doctors. I am also talking about religious beliefs, because they say that if you believe, you may stand up and be healed' ... I am also hoping that after some time, they will be accommodated because we need

everything, prayer, holy water, bark or leaf of a tree if it works. The fact is we do not understand each others cultures and that is why there is such a gap ...

With counsellor 2, it seemed as if there was a general expectation that failure to comply is not readily acceptable particularly if there was counselling input,

...most of them do not easily believe that there is no cure. I do not know if this is caused by denial.... you will find that if you give them results today and tell them to come in three months time, they will not come back for a year even though you have counselled them.

Clients showed preference for treatment that they experienced as effective. Client 2 who reported preference for 'treatment from Somerset' also believed in the treatment that she had obtained from a faith healer. It seemed as if using two or more forms of explanations, as well as treatment, was preferable. While at a lower level, doctor and traditional healer were acknowledged, there was also a belief in the supernatural (ancestors), and divine intervention (God) with regard to what, when and how they would ultimately survive HIV/AIDS or die. This seemed to be more acceptable, containing rather than placing all their hopes on ordinary man. Client 2 reported,

AIDS can be cured by man, but there is nothing that surpasses prayer. Even if you are using the person's/man's treatment, you also rely on prayer. Help does not come from man but from God.

On another level, traditional healing and medicine were given their respective and unique platforms with regard to the role that they played in 'curing' or alleviating symptoms by improving appetite and in healing by contributing to the general improvement of the wellbeing of a client. Medicine was given the accolades for the 'curing' while 'healing' was attributed to traditional intervention. Client 3, who was treated for TB, states that using both medical and traditional medicine helped him but attributes these to the supernatural, God and his ancestors,

... amaWethu are my relatives who are late and who are obviously closer to God than I am and their eyes are watching me. They are in a better position to appeal to and plead with him better than I can. And that is why I bring them closer to him ... I would go to the medical doctors but where my hope lay was with the black healers I believe that what has really helped me is the black treatment. The white one there was some help with the tablets that I was taking 'more especially with appetite'. Even gaining weight, I am normally 63kg

but yesterday I was 67kg. I was never that heavy. As for the improvement in my health, I believe that was as a result of 'isiNtu'³

There was also a perception that client 5 would continue with the medication. This was on account of the power, legitimacy of the institution and recognition that failure to comply would result in some form of punitive action rather than the effectiveness of medicine.

The reason why I use pills is because it is the law, I was told to continue eating the pills. I do this because when I go back to them for help, they will not say I did not do what I was told. (client 5)

It would seem that all counsellors believed in the medical forms of healing to be the most appropriate while clients used a wider repertoire of explanations about treatment. Clients accorded equal weights for medical and traditional forms of healing, thereby granting greater power to the supernatural and divine intervention. It appeared that clients took medication because of compliance rather than their belief in its effects.

Effects of treatment

There were some misgivings in terms of the effects of available treatment: some counsellors were doubtful about the effectiveness of treatment.

I do not think that it is completely adequate because the body may not respond to its effects and the person will immediately get full blown AIDS

Counsellor 3 had similar views,

... it's only that one has 'longer living space but you eventually die ...

What also emerged was that the effects of treatment were perceived by counsellor 1 to be short term and basically aimed at boosting the immune system in order to protect the body against opportunistic diseases,

... blood cells in your body can fight or overcome diseases, but with the HIV virus, they are not strong enough, they are sort of tired. All the people die of diseases such as pneumonia, TB which if the person had antibodies are not normally killing. The person can be helped even with medication if they are not strong enough to help him.

Clients (n=5), identified the effects of medical treatment, traditional treatment or divine intervention. In some cases the effects were separated; in others they were combined. For client 2, medical treatment was the solution,

I like pills from Somerset ...they helped me when I was so ill that my weight was 32kg, tall as I am, but it is now 71kg. (client 2)

However, for client 5, traditional treatment and medical treatment were a way of maximising chances of improvement. It also seemed important that he understood the immediate effects of the treatment and that other processes be gone through before the cure was completed,

All I'm trying to do is to get well ... I also go to the the healer to take a bottle of herbal mixture ... now I have have noticed that it is rupturing/bursting ... it comes out of my throat through my mouth dirty phlegm comes out when I induce when I induce vomiting'.... idliso has been softened or soaked before he can give me something to remove it

For client 3, there was a similar recognition of the functions played by each type of treatment. It also seemed as if the kinds of treatment were compared according to effectiveness or overall improvement in health,

I believe what has helped me is the black treatment. The white one, there has been some help because the tablets of which I was taking about 8 per day. So can say that have helped more especially the appetite ones because I had none at all. When I started using them I ate a lot. Even gaining weight, when I am at my heaviest I weigh 63 kg, but yesterday, I weighed 67kg. I was never that heavy. So I do believe that I have gained weight because I was eating a lot and that was because of the appetite tablets. As for the improvement in my health, I believe that was as a result of 'isiNtu'..... I do not have anything even those symptoms which the sister told me about and which I identified in myself, they are not there. I believe I am cured since that idliso was taken out, you understand.

What emerges from the above is that all counsellors have reservations about the long-term effects of medical treatment, but acknowledged its effectiveness as a short-term solution. On the other hand, clients described the effects of medical treatment as positive, especially in terms of weight improvement. However, some of the effects of these included were those of other forms of healing such as faith-healing.

3.5 COUNSELLING ROLE AND EXPERIENCE

The last part of the interview material was completed in order to ascertain how counsellors understand their role and its effects. It also looked at both counsellors' and clients' experience of counselling and their perceptions of each other.

Explanations of the counselling role

The counsellors' explanations of the counselling role varied. Community workers perceived themselves as 'counsellors' (n=2) while the professional nurses (n=3) described their roles as 'nurses doing counselling'. In some cases, the counselling role focused on a one-to-one relationship with an information and supportive component.³

I explain to them that I am a counsellor. They usually ask what a counsellor is and I tell them that a counsellor is a person who helps you carry your difficulties or problems, that is if they have acknowledged having a problem.....a person that you can talk to and whom you can tell what is troubling you and then when you have 'poured out' your problems, they will refer you to a social worker or other places and you feel better afterwards (counsellor 2)

... firstly I see them so that they can have someone to whom they can air their problems, thoughts, feelings whether these are positive or negative so that I may be able to carry some of the problems and also give information where they do not understand. I usually tell them my name and that 'I have come to you as a person come to share with you information about things that you may share amongst yourselves. (counsellor 1)

Other counselling roles which demanded a shift across different social contexts. Nevertheless, the counsellors recognised their primary role, its principles and responsibilities in health-care structures.

I am known here as a nurse ... in church they know me as sis B but my work is this - there, I often say 'I have knowledge of AIDS and I may be able to answer some of your questions' but I would not say that here at the clinic. I would do it fully. When I do health education, there is no privacy and confidentiality, but in a counselling context, I have to build up his trust.. (counsellor 3)

For counsellor 4, this was the case,

if you are a nurse, you are everything, you are a counsellor, nurse, doctor. I see myself fitting in all kinds of situations ... you must be able to change roles or else you end up losing people

What also emerged was the need for the counsellor's availability to be reflected in the code of dress. Counselling while wearing a uniform was perceived as a barrier.

I do not believe in wearing uniform because it makes you feel distant from them. And when they see you wearing that, they associate you with some authority and they may end up avoiding you because it's like you are from the police. If you are wearing uniform, they will give you all kinds of responses which they think you want ... (counsellor 4)

It also appeared that, apart from the constant shift in roles, the dress code, there were positive rewards in terms of the feedback from clients:

... I feel good more especially when I see that he is getting the help that he needs.(counsellor 4)

'With counselling, I've discovered that you end up dealing with social problems, that's the only time when you know that you have brought some relief ... and they say 'that feels better'. I don't know what it is but you don't just help this person cope with the feelings and emotions, but at some stage, you have to act to show that this is what I meant ...' (counsellor 2)

It was also necessary to recognise a person's limitations of counselling and the feelings that often result when objectives are not achieved. Sometimes, when counsellors were stretched beyond the limits of the role, they felt both abused and overwhelmed :

'... but where I fail, right enough I do refer, but it becomes painful. Sometimes, I sit and think, it feels as if I am abusing myself - you see there is no way that I can be gxalabalibanzi/one who carries everything' ... there are people called specialists who can do the work.'

... you will find that these touch you so much that they close you up - it becomes very difficult to handle the situation. He will sometimes want to come to your house and 'phone at any time and want to depend on you. I usually feel bad, I feel angry ...

The emergent themes reflect varying perceptions in the way counsellors perceive their roles in relation to clients. While some perceived a strong supportive component in their

counselling role, others perceived counselling as one facet of their numerous roles. Counsellors, to a large extent, acknowledged that their efforts to assist clients had contributed to a positive sense of self-worth, while the intensity and complexities of clients' difficulties contributed to feelings of being overwhelmed.

Explanations of counselling experience

Counsellors' (n=5) and clients' (n=5) explanations of the counselling experience and perceptions of each other varied between the two groups and also within each group. For example some counsellors (n=4) viewed their clients' behaviour despite counselling input, as irrational and difficult to contemplate. Their views about clients' behaviour reflected to some degree a sense of antagonism:

... more especially to the ones who often come here I would think I'm seeing this patient for the 20th time. Even you can see it in their files and when you examine them. Not that you are looking down on them, you wonder why their files look like this ... thick you know. You can them tell them of STDs and that in the long run, they will get UGawulayo.⁴

they sometimes 'tuja'⁵ - like I have given up on one of them. I have said when he is ill, he should come back. They tell you that 'lidliso' or 'libekelo'⁶ or they will say 'weqile' or 'weqe umkhondo'⁷. Those are really the difficult ones more especially if you want to make them understand

It is important when you are going to counsel a person to note that we are at various levels, with a person like you I would not talk about soldiers, we would talk anatomy. Let me make an example a person with TB, they will say 'it's not TB it's idliso'. When you tell them about HIV/AIDS, they can hear you, at the back of their minds, the person has a witchdoctor, that cures incurable things so he half believes you when you say that it is incurable. There is also a notion that whites tend to have incurable diseases. Now, you have to start from there, it is useless to oppose and explain it in the Western way ...

On the other hand, some clients (n=2), perceived counselling as a positive experience. One reported reservations and others (n=2), had little to say and were thus unable to link what was shared with the role of counsellors.

Client 2, who reported having initial reservations about engaging with counsellor 2 because both of them shared the same neighbourhood said this about their relationship:

there is a difference in the way that doctors tell you things, they talk faster, and tell you even the number of years, but the counsellor gives you hope always and puts an end to those feelings and thoughts such as counting your years of life. The counsellor makes you feel as if you are person amongst people ...

Y told me that her work involved sharing and guiding people who have this disease and those who have not got it yet. That helped a lot because I was in darkness and I could never make sense of the treatment I was taking. She helped me a lot that way. She told me that I would think a lot when I was alone. That was helpful too.

However, client 3 was not only reluctant to talk about the nature of the counselling experience but also denied the existence of a relationship. Her openness was reflected negatively and her role as a counsellor was disqualified. It seemed as if gender was also an obstacle.

No, it's not like that at all. I do not get that close to females. All I know is that she is someone who is treating me according to the rules. She was very open, she certainly calls a spade a spade and not something to dig the soil with ...

But, client 5 was unable to comment on the counselling experiences and perceptions. It seemed as if there was some indifference or shock to what was happening.

I cannot really say, because my head was spinning at the time as I had just come out of hospital. I know only the things I have told you, if I did not, then I do not know. That is all I can tell you.

Counsellors' and clients' perceptions about each other varied. Firstly, counsellors in their predominant use of the medical model seemed aware but unaccepting of the different approaches more particularly the traditional approaches used by clients to explain the condition. Secondly, it seemed from the manner in which counsellors described clients' behaviour and beliefs that they regarded them as irresponsible and irrational, in their choices of explaining and treating AIDS. On the part of the clients, it appeared that there were some clients who had a positive counselling experience. There were also those who were reluctant or indifferent to comment about the nature of the relationship as well as those who claimed not to understand and denied the role of counsellors more particularly nurse-counsellors. This seemed to be somewhat consistent with the way in which the nurse counsellors perceived themselves.

3.6 DISCUSSION

This analysis illustrates both similarities and differences in the counsellors' and clients' explanations of aetiology, course, treatment, prognosis and counselling experience of HIV and AIDS.

The main themes that emerge from the analysis of the interview material reflect qualitative differences and similarities in the way in which both groups of participants explained their understanding of the disease.

Firstly, the differences reflect that counsellors' explanations are predominantly objective and medical while those of the clients are concrete and derived from personal experiences. Secondly, counsellors elaborate on medical explanations whereas clients stress personal experience. Clients also seem to impute the human agency to the condition while counsellors tend to use passive notions of anatomical or bodily processes. These differences indicate a need for greater understanding of the complex issues which may inhibit counselling objectives if not understood.

The other emergent themes from the material are illustrated in counsellors' and clients' explanations. For example, the manner in which counsellors identify populations that are at risk of infection uses as determinants sexual orientation, clients' actions or activities and personal characteristics. These had a strong element of pathologising and a tendency to identify them as a group.

Although clients identified some similar patterns, their explanations focused on their personal experiences. They seemed to emphasise particular circumstances and often blamed other groups or bad luck for their infection. What is important is that both counsellors and their clients seem to label those seen as irresponsible. This suggests that the attitudes and social stereotypes associated with certain people attitudes may have

implications for counselling. Not only are these stigmatising and categorising certain clients, but they also hinder the principle of unconditional acceptance which is crucial in counselling people who are at risk or already infected with HIV/AIDS.

What also emerges as important is the competing biomedical explanations with the traditional, natural and supernatural explanations of the condition. It appears that while counsellors confine themselves to medical explanations, clients use a wider variety of explanations and manipulate these when it is advantageous to do so. In particular, clients use medical information from counselling scenarios with their own experience and description of symptoms but do not necessarily acknowledge the medical explanation.

This suggests that clients use the various explanations to empower themselves in a situation that they see as disempowering. Because AIDS is a condition associated with poor prognosis, by denouncing the biomedical model, using other explanations gives them a sense of control and continuity not offered by the medical explanation.

What also emerges from the interview material reflect some similarities between the two groups and differences within the group of counsellors. The similarities are reflected in the way in which some counsellors and clients view themselves in relation to one another. The counsellors view their role as ambiguous and this, to some extent, appears to be shared by the clients. However, there is some variation in that certain counsellors stress a supportive role, while other counsellors advocate for education.

End Notes

1. idliso - refers to poison with mystical qualities prepared according to specific instructions and rituals, in such a way that affects only the person(s) it is intended for. For example, in a case where it is sprinkled over food it does not matter how many people sample that food. It will only affect the person whose name was called when it was prepared.
2. Person - used synonymously with traditional healers.
3. isiNtu - used synonymously with traditional healers.

4. uGawulayo - folk name for AIDS, derived from 'ukugawula' meaning felling trees.
5. tuja - pretending not to understand or to be stupid.
6. ibekelo - a preparation wherein a handful of soil is picked from the footprint of the intended victim, prepared according to specific rituals and sprinkled around the area where the victim is likely to walk, e.g. in front of the entrance door. Is said to harm only the person it was intended for.
7. weqile/weqe umkhondo - symptoms acquired when a person unknowingly walks on the trail of evil and witchcraft creatures.

CHAPTER FOUR : CASE STUDY

The second and last part of the analysis demonstrates how both counsellors and their clients use their explanations and meaning to empower themselves in various situations. A case study drawn from counsellor-client transcripts and analysis demonstrates the importance of explanations, their meaning and role for each participant. The discussion that follows analyses some issues that emanated from the previous analysis and the case study and explores additional approaches that may be used to enhance counselling objectives.

4.1 PATIENT SUMMARY OF BACKGROUND INFORMATION

DJJ (client 3) is a man of about 45, who lives in Khayelitsha. He is a long distance truck driver for a refrigeration company in Cape Town. He often travels alone to neighbouring countries such as Zambia, Namibia, Botswana, Zimbabwe, Mozambique and Angola. He also goes to Johannesburg, Durban, Pretoria etc. He has been employed by the company for about 10 years. He has a girlfriend of 18 years and they have children aged 12 and 5 years who stay with his parents in the Eastern Cape. His girlfriend is doing a computer course in Johannesburg.

4.1.1 History of Illness

DJJ reports that he came to know about his diagnosis when he became ill on one of his trips. He does not remember how he came to stop and park the truck on the side of the road. He believes that 'AmaWethu' (his ancestors) came to his rescue during that time. He woke up in his driver's seat, his head lying on the steering wheel. He felt dizzy, had no energy and was shaking. He was subsequently admitted to Tygerberg Hospital where he was diagnosed HIV positive with TB. DJJ reports that he did not want to be 'tested' because he could not see a reason for a blood test if there was no cure, but agreed

anyway. He remembers feeling 'shocked' and not believing that he really 'had this thing'. He could not understand what was happening and could not disclose having 'this thing' to his girlfriend. However, he believes 'deep inside that there is nothing like that inside' him.

4.1.2 Explanations of HIV/AIDS

DJJ was discharged to a local day hospital for further management. He also received post-test counselling from counsellor 3 whenever he reported to the clinic for his medication. He reported feeling confused as to how he might have acquired the virus or how he might infect another person 'except if I am sleeping with that person'. He also mentioned that this contradicted what he saw on a video at one clinic where it was explained that 'a person cannot get infected through sexual intercourse and not through kissing'. What also confused DJJ was that he was almost 'two months without a woman', having taught himself 'to have self control and not sleep with a woman daily'. This arose from the fact that they (truckers) are 'often discriminated against, the mistake is that people make it as if this comes from the person inside'.

However, DJJ had a girlfriend in Durban and another one in Johannesburg who were staying at the township; 'not like we are labelled as people who run around trying to collect women from all over'.

He acknowledged the counsellor as 'someone who is healing me according to the rules, who calls a spade a spade and not something to dig with'. He had been told by the counsellor about AIDS and that 'there are soldiers which guard the body and that this thing targets these soldiers and eats them until they get depleted'. He also understood that the person 'who has it sometimes feels alright, it is something that comes very slowly to the person'. The result of this is may be things such as persistent sores because 'one's soldiers have been eroded from day to day, hour to hour and that one finds oneself vulnerable to all kinds of diseases' when the body is not protected any longer. At the same time, he was told of symptoms such as weight loss, night sweats and poor appetite.

He was experiencing all these. His view is that 'it was possible to lose weight because I was sick'.

4.1.3 Beliefs about Treatment and Healing

DJJ continued with the treatment but also consulted a traditional healer for another diagnosis and treatment. He also informed his work supervisor that he needed to consult 'osiyazi' on the grounds that 'we blacks have our own idiosyncratic things which are ours only and these cannot be understood by white people'. It took two months 'of being handled by our black people' who also diagnosed him with 'idliso'. He was also informed that 'it is situated in the lungs and in such a way that it will definitely be identified as idliso'. DJJ asked the healer to 'crush idliso' that was identified and he was given herbal mixtures. He felt better and now believes that he is cured since idliso was removed. He acknowledges both 'black and white treatment'; he believes that the 'white one' helped improve his appetite and thus weight (50kg-67kg) because he was given medication. The improvement in his health is attributed to 'isiNtu'. He believes that he has idliso and not TB. His uncle had TB and he coughed while DJJ does not cough at all. He also believes that it is because he has idliso that he could not infect his partner or anyone. Idliso is not infectious; 'if it's meant for you, it's yours and a person can never get it from you'.

4.1.4 Beliefs about Prognosis

DJJ believes that only God will determine when and how he will die. Both medical doctors and traditional healers are created by God. He prays to God so that both these may be given the powers to heal him. He also believes in 'amaWethu' (his ancestors) who are closer to God than he is and can appeal to Him better when God is not listening to him. DJJ believes that he has been cured by traditional medicine and 'does not care about the diagnosis'. He believes that he is not HIV positive although he cannot say there is no such thing. Another explanation given by DJJ is that 'there might have been a germ that was identified' but he was unable to say what it was.

He states that when he gets sick, he will have another blood test as if he were doing it for the first time and will not disclose his status. He hopes that the result will be negative in which case, he will show it to the researcher.

4.2 COUNSELLOR SUMMARY AND BACKGROUND INFORMATION

C3 is a professional nurse at a clinic in Khayelitsha. She became involved in HIV/AIDS work in 1989 after completing her first counselling course. She started off with a some referrals but since a growing number of people needed counselling, she became more involved. C3 is the only counsellor involved in counselling at the clinic. Among the experiences that she learnt from the course, she cites 'observing behaviour, listening skills, awareness of body language and cues.' While these skills help her understand her patients better, she argues that from her experience, 'counsellors can be thrown off when it comes to our people because of lack of formal education and culture'. She defines her role as that of a nurse with counselling rather than as a counsellor. She reports that sometimes she feels she and other nurses are not equipped to deal with the patients' complex problems.

4.2.1 Explanations of HIV and AIDS

C3 defines the HIV as a virus 'that is preventable' through sexual behaviour and other practices. She identifies sexual anal and oral intercourse, blood transfusion, from mother to an unborn child, during delivery, breast feeding and when one has a cut in the mouth as the main ways in which the virus can be transmitted from one person to another. She maintains that HIV 'kills the white cells which are the body defence' and this leads to the immune system being dysfunctional and thus unable to protect the body. She also defines a person with HIV as a carrier who has the potential to infect other people, while with AIDS, the person presents with 'symptoms and opportunistic diseases' which indicate that the body can no longer fight for itself.

4.2.2 Explanations of Symptoms and Duration

C3 mentions that the symptoms of AIDS are no different from those of a person with an ordinary ailment but cites body sores, consistent fever and diarrhoea which do not respond to treatment as characteristic of the later stages of infection. Some of the factors which would motivate her to test for the virus, would be knowing the person's history and lifestyle. She would test 'a truckdriver who goes out on long trips, a prostitute, a person who has multiple sexual partners, drug addict, and a homosexual'. These would not be final determinants, however. She would also see if their ailments persisted despite treatment.

4.2.3 Explanations of Treatment

C3 maintains that 'our people know about HIV and AIDS and they hear about it through the media. She believes that 'it has not sunk in how serious it is'. Clients 'half believe' when told that it is incurable 'because at the back of their minds, the person has a witchdoctor that cures incurable things'. She further reports that there is a notion that 'whites have incurable diseases' which can be cured by traditional healers. C3 sees the gap in healing and attributes it to a 'lack of understanding between the cultures'. She criticises 'Western culture where 'everything should be done in a test tube and measurable'; for not allowing traditional knowledge to develop, but merely labelling it 'heathenhood'. She believes that traditional healers 'who are genuine should be brought closer' as they may help with certain diseases because some of them are 'shown visions while they are asleep'. She reports that forms of healing such as 'prayer, holy water, bark or leaf of a tree if it works', should be recognised.

4.2.4 Explanations of Counselling Role and Experience

C3 maintains that a counsellor has to respect 'the patient's right to privacy, to assure the patient's of confidentiality, and build up the person's trust'. This is impossible at times because, it is also the counsellor's responsibility to protect other professionals who are also involved in treating the person against infection by disclosing the person's HIV

status. When counselling, she first assesses the 'level of understanding' of the person. With those who have little or no formal education, she tries to explain HIV by creating a picture of what she is saying.

As a counsellor, C3 believes that 'one should be at the level of the patient's belief and refrain from opposing what the person believes'. With the 'educated', she talks 'anatomy', but with those who have consulted a traditional healer and believe that they have idliso, she explains to them that 'idliso has ruptured, thus boring a cavity in the lungs'. She also informs the client that the cavity where there was flesh, cannot be cured by the traditional healer. If the patient takes medication, 'the cavity will close up again and idliso will be cured'.

4.3 CASE STUDY DISCUSSION

The summaries presented in the last part of the findings illustrate some of the issues that emerged from the respondents' explanations of HIV/AIDS. This discussion will an analysis of the counsellor-client case study; the explanations that they choose, the motivations that they have for such choices and how these choices help them control their environment.

The description of AIDS appears to have historical links with the attribution of AIDS with specific groups of people locally and worldwide. For example, the social stereotypes characterised associating AIDS with certain groups of people such as truck drivers or homosexuals is still predominant. The meaning that is attached to its origins distances and help create and maintain social stereotypes. The discrimination directed against DJJ as a trucker driver serves to protect 'good' people, while it alienating 'bad' deserving people. For C3, it seems to have some benefits in that it becomes easy to associate good clients with herself. For the bad clients, however, it helps attribute infection to the

unacceptable characteristics of the client, in a way saving herself from feeling powerless and having failed to encourage compliance in her counselling activities.

The reported lack of understanding and subsequent resistance by DJJ to HIV blood-testing if no cure was available for the disease, indicates a power struggle between him and the health-care system. The bargaining that takes place before can be seen as a means of gaining some control of a situation that was made distressing by the medical explanations of AIDS. This situation can also be seen as trapping because of the necessity for a blood test. He perceived himself to be powerless, and the limitations of his power made it difficult for him to resist giving consent for the blood test. In spite of the resistance and bargaining, he was aware that he would be seen as oppositional or noncompliant.

DJJ describes his diagnosis as 'this thing' rather than AIDS or HIV. This appears to indicate the unacceptability of the medical diagnosis and he uses this term to distance himself from the fears and emotions associated with AIDS. By identifying 'this thing', the condition remains unknown and has the potential to be called anything other than AIDS. This seems to bring some form of relief as it helps DJJ escape the fears of death and dying that are predominantly associated with the condition.

The function that has been achieved seems short-lived, however, because he maintains that he will go back and have another test to prove that it was not AIDS but something within the domain of his understanding.

Another related factor is the identification and diagnosis of the disease as 'idliso'. This diagnosis seems to mean TB, on the one hand, while it appears to substitute for AIDS on another. While the TB diagnosis is within DJJ's awareness, it is not fully acknowledged. The 'idliso' diagnosis fills in the gap that was created by the TB diagnosis associated with AIDS diagnosis thus giving him some relief.

In his articulation of the disease, there seems to be a tendency to create opposites of events or 'one versus the other'. These develop into a comparison between events that are controllable and those that are uncontrollable. Furthermore, the series of opposites extend along racial lines between blacks and whites, in terms of doctors, diagnosis, treatment, and related improvement. It would seem that DJJ perceives 'white events' to be alien and associates them with unfavourable consequences. On the other hand, black events seem to be associated with favourable consequences.

Both 'black and white treatments' are weighed on an equal scale by the clients while he uses the supernatural forces (God) as superior to both. In a way, this enables him to make choices to escape the feelings that are evoked by the poor prognosis associated with AIDS. By making these less powerful, he empowers himself to manipulate the choices and solutions whenever he needs to.

DJJ also uses the phenomenological experience with his 'ancestors' to articulate his vulnerable position. It provides him with a unique and deeply personal, cultural and religious link with his ancestors and God which no other person can have access to. It provides him with a safe and protected feeling that nothing can touch within the containment of these supernatural and divine forces. DJJ does not acknowledge the counsellor's role as it seems to evoke anxiety and powerlessness.

On the other hand, C3 seems to lack clarity about her role. This is partly due to the ambiguity about multiple roles and her reported inadequacy about counselling skills and knowledge. Although these seem difficult to manage on another level, these roles are also used to help assert her power in various contexts such as with doctors and patients.

C3's use of a medical model does not mean lack of awareness of other forms of explanations, but may be an attempt to fit in with what they perceived to be the characteristics demanded by the situation. The roles of the researcher and her

involvement with counselling may have been contributing factors in terms of the kinds of explanations that counsellors chose rather than assert their traditional knowledge. This in a way serves to assert her medical knowledge and power with the researcher who was perceived to be medically inclined.

With C3, it would also seem that the aspects of traditional healing that she shares with 'our people' were her own views although she presented these as client's perceptions. This becomes clear when she asserts her position by criticising 'Western culture' for ignoring traditional knowledge. This could be because the researcher was initially perceived to be medically inclined because of her role as a counsellor, but later C3 asserted her position in line with her interests. This suggests that information will be processed in such a way that serves the particular needs of the moment and these needs may become negotiated and reviewed at any given time. For C3, using different kinds of knowledge, empowers her in relation to the researcher and her clients by ensuring her control in counselling scenarios.

CHAPTER 5: SUMMARY

The analysis of the interviews illustrates qualitative differences and similarities in the participants' explanations of aetiology, course, treatment and prognosis, as well as in their views of counselling role and experience.

On the basis of the analysis of the interviews, it appears that there are some qualitative differences in the ways clients and counsellors formulate their understanding. Counsellors elaborate on medical explanations, whereas clients emphasise personal experience. Counsellors use objective explanations of bodily processes whereas clients stress the human agency to the condition. Clients also use a wide repertoire of explanations for the aetiology, the course and treatment of the condition. These explanations were the :

- personal: where they attribute the causes to themselves and their actions
- natural: where AIDS is attributed to the geographic areas and the environment
- social: where the disease is seen to be caused by others' personal malevolence
- supernatural: where the disease is attributed to the divine intervention from ancestors and God.

In spite of these differences, the material also suggests some important similarities between the counsellors' and clients' explanations in that both use social stereotypes and personal characteristics such as sexual orientation and occupation as determinants for infection. There were labelling connotations for those who are infected or who are likely to infect others. The counsellors view their role as ambiguous and this, in certain cases, was also implied by some of the clients.

What also emerges from the analysis of the interviews is that both groups use the information in order to assert their power and to gain control in a variety of situations. The discussion that follows examines the findings of this study against the framework of counselling objectives. These objectives include:

- Disseminating information aimed at treatment and prevention
 - Providing support and giving guidance to those who are at risk of infection or are already infected
 - Reducing distress and enhancing coping abilities.
1. Information-giving is an essential part of counselling process. It may be viewed as a starting point to the extent that the biomedical explanation is clearly understood by the clients who need to comply with counselling objectives and thus modify their behaviour. It seems from the analysis that counsellors expect behaviour change from clients after counselling input. Clients' behaviour change, however, is often contrary to counsellors' expectations and includes emotional reactions and high-risk sexual behaviour.

From the analysis, there seemed to be an underlying assumption that counselling is equivalent to behaviour change. The counsellors were also confused that clients, whom they reported to be informed about the biomedical explanation of AIDS, were not acting on that information. It would appear that the assumption that people act on information is not necessarily true. Information is not the only factor that determines behaviour change. Some counsellors reflected that clients who engage in high-risk behaviour may not have reached a point where they accept their HIV status and are still working through different emotions. It may be deduced that those clients who have already accepted their positive diagnosis status are less likely to react the same way. It thus seems important for counsellors

to understand the factors that motivate behaviour as these may help them to understand their clients better in order to support them.

2. The provision of information to the infected and uninfected also aims to prevent infection. It helps alleviate stress, assists in coping with diagnosis and enhances the management of the disease through a healthy lifestyle. It is based on the client's understanding and acceptance of the medical explanation of the condition.

However, there was a discrepancy between the two groups of respondents in how information was disseminated. That clients related personal experiences also indicates a need for their experience to be acknowledged. Illness is perceived, experienced and coped with and lived by clients as an experience that is unified (Good, 1992) and that calls for understanding. It seemed that the clients failure to 'comply' with this expectation created difficulties for them. Stein *et al* (1994) argues that although compliance tends to be widely used in counselling scenarios, its origins are biomedical. Its instructive connotations are questionable when it is used in counselling because it does not reflect the principles of acceptance and recognition of self-determination which form the cornerstone of helping professions.

On the basis of these objectives and the paradigms within which counselling is based, counsellors should examine and recognise any obstacles which may hinder the counselling objectives. This does not imply that clients do not need biomedical explanations. However, it is important for counsellors to understand the reasons why clients choose to use other explanations or do not behave as expected.

3. Providing support is documented as a counselling objective. One aspect involves enhancing coping capabilities and decision-making. Any counselling scenario

involves an interactional process where both counsellor and client play a role (Sue, 1990). Ideally, they are free to introduce their own respective knowledge and beliefs. These would appear to be largely determined by factors which include the nature of the relationship, the degree of awareness, sensitivity and skill on the part of the counsellor. While these may not be the only factors, they are ingredients that play a role in the extent to which support may be provided.

The way in which information is utilised affects the development of a supportive relationship. Both counsellors and clients use information as a tool to assert their power and control over each other. The case study reflects the use of medical framework by counsellors without acknowledging the other explanations that clients may use. The clients may be left feeling disempowered, particularly in situations where they feel threatened. Depending on the context, clients may use explanations which make them feel less threatened and more in control.

Counsellors, on the other hand, feel overwhelmed and disempowered by the clients' disregard for what is good for them. The feelings of uncertainty and ambiguity become projected as failure and may be reflected as blame and antagonism. Counsellors also identify, to some extent, with the clients' cultural needs and the shared culture from which beliefs emanate. However, other roles and the relationship that counsellors have with health systems impinge on this. No further developments, other than to fulfil a loyalty and responsibility to the medical profession, are allowed.

It becomes difficult, even impossible, for counsellors and clients to establish an understanding. It limits the ability of counsellors to focus on the experience of clients; in other words, what it means to be afflicted with an incurable disease what strategies have been worked out to cope with it, as well as the expected prognosis. The positions taken by counsellors and clients lead to pathologising

rather than seeking understanding. They attribute clients' understanding and beliefs to being 'not city wise'; 'illiterate'; or 'pretending to be stupid'. These attributions prevent dual understanding and support that is often needed by clients.

The ambiguity surrounding counselling, its boundaries, and the role of the counsellors have been debated. This problem appears to be due to a lack of awareness of its operational parameters and the demanding roles rather than the competence of the counsellors. There is a need to examine the boundaries within which counselling should take place and also how counselling should be incorporated into the overall health services. There should be accountability of commitment whereby counsellors from any discipline can own it as an essential service to be provided to clients or patients.

4. In the light of the findings, it is necessary to review the issues that were examined in the discussion. Further suggestions are made to compliment the existing body of knowledge that has been accumulated and documented on AIDS literature.

The need for support as well as for people to be supervised in helping professions has been well documented. It is important for counsellors to have support and supervision in order to heighten their self-awareness and to grow professionally. These will also improve their self-confidence. Counsellors who are aware of themselves and constantly reflect on their role are likely to be supportive of their clients.

Findings reveal that clients understand the biomedical explanation of HIV/AIDS but use a range of explanations for aspects of their ill-health. Cross-cultural researchers advocate for the indigenization (Kleinman, 1980) or democratization (Reynolds & Swartz, 1993) of health care, through which changes occur in

medicine and psychiatry when these are practised in non-Western societies. This arises out of the recognition that clinical interaction and health care may be improved by an awareness of clients' explanatory models. In South Africa, social inequalities, unequal relationships and issues of race in health care are mirrored in health-care systems and woven into the fabric of care (Swartz, 1991b) because white doctors predominantly render services to African or black patients.

It is essential therefore, that counsellors understand clients' explanatory models, their therapeutic role and their positive effect on compliance and counselling objectives. It would be useful for trainers to incorporate strategies whereby counsellors are made aware of these differences and are trained to negotiate and make room for clients' explanatory models.

Another kind of support by the counsellors would be to train community workers and utilise them for counselling and education campaigns.

Lastly, on the basis of the qualitative nature of the study, it should be noted that the findings regarding the counsellor and client population cannot be generalised. This may be limiting, bearing in mind the growing number of people infected with HIV/AIDS. The study provided an initial exploratory investigation of explanations between two groups of participants. From the findings, it would appear that a relationship can be developed between the medical explanations and lay explanations of HIV/AIDS. Further investigations, using a larger sample, may generate greater understanding where results could be generalised to a wider population.

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