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# **CRISIS AS CHALLENGE: COUNSELLING COUNSELLORS, PERSONS LIVING WITH HIV/AIDS AND SURVIVORS**

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## **ABSTRACT**

The following paper focuses upon the crises and challenge facing all South Africans as the AIDS pandemic escalates. It briefly discusses the broader implications of the pandemic for the economic and social well-being of the South African population at large, and then attends to issues associated with the counselling of persons living with HIV, the counselling of counsellors and the counselling of the survivors of families and groups affected by AIDS-related deaths.

The paper first distinguishes between reality-based concerns and transference responses for persons with HIV, and suggests that counselling these persons is supportive rather than dynamic in its focus. Thereafter various countertransference responses are identified. The paper suggests that counsellors will themselves require counselling and support if their continued involvement in the counselling and care of persons with HIV is to be assured. Finally, the possibility of large scale delayed and complicated grief reactions among the population at large, as a result of multiple and continuous losses of friends and family to AIDS-related deaths, is addressed.

The paper evaluates possible intervention strategies for dealing with the pandemic and argues that while education programmes are laudable, more emphasis will need to be placed upon dealing with the crisis at hand. The training of counsellors and caregivers, as well as bereavement counselling of the population at large will thus need to take priority. The paper concludes that while AIDS is a devastating and tragic pandemic that will affect all levels of our society, the pandemic also offers an opportunity to rebuild and reintegrate South Africa's shattered 'community of communities'.

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## Introduction

AIDS, or the acquired immune deficiency syndrome, was first formally diagnosed in the United States of America in 1979 (D'Anzi, 1987). While in developed countries most infected persons apparently remain homosexually active men, intravenous drug abusers, and/or the recipients of contaminated blood products (Gong, 1985; Cochran & Mays, 1989), incidence of the disease has been reported worldwide and is manifest pandemically in both males and females in central (Biggar, 1986) and southern Africa.

On a local level, Department of Health statistics (Jackson, 1994) suggest that HIV-infection cases in South Africa are doubling every 11 to 13 months, with 95 per cent of new infections being heterosexually transmitted. These estimates, based on blood tests of pregnant women and extrapolated to the population at large for the age group 15 to 40 (and allowing for a 30 per cent lower infection rate for men) suggests that there were 550,000 economically active HIV-positive persons in November 1993. Allowing for a conservative doubling period of 15 months, the figure for the end of 1994 is estimated to be between 850,000 and one million persons. In view of these statistics, AIDS can no longer be termed a 'gay plague'; rather, it must be viewed as a behaviourally transmitted disease (Cochran & Mays, 1989) that resists safe sex education initiatives (Odets, 1993).

The following paper focuses upon the crisis and challenge facing all South Africans as the pandemic escalates. It discusses the issues pertaining to the counselling of HIV-positive persons, the counselling of counsellors, and the counselling of the survivors of families and groups affected by AIDS-related deaths. It argues that while AIDS is a devastating pandemic that will affect all levels of our society, like the Chinese symbol for crisis, it also offers an opportunity and challenge – to care for our bodies, to care for others and to face the inevitability of our human mortality with dignity rather than fear and denial.

## Prevalence and Controversies of Cause: Implications

On an individual level, no person has been known to recover fully from HIV-infection (Dunkel & Hatfield, 1986), and the vast majority of persons (as much as 95 per cent) die within seven to ten years after contracting the virus (Jackson, 1994). In other words, infection is almost always fatal, although there are a number of long-term survivors.

The transmission of HIV, however, remains something of a mystery despite medical advances. Medical researchers such as Deusberg (cited in Guccione, 1994) and Root-Bernstein (1993) continue to challenge every single theory about

how AIDS is caused and how it should be treated. As Dunkel & Hatfield (1986:114) suggest:

*"...the underlying cause of the disorder has not been determined nor which risk factors are causative and which are contributory...Researchers suspect that it is a transmissible agent...and suggest that the viral infection is spread through sexual contact and blood contact and by vertical transmission from infected mothers in utero or during delivery. Currently, no evidence indicates that AIDS is spread by any other method" (emphasis added).*

Moreover, these and other authors in the field (Evian, cited in Jackson, 1994; Isaacs & McKendrick, 1993; Hays, 1984) propose several co-factors that either create the conditions under which HIV becomes activated, or determine a person's susceptibility to the virus. These co-factors include: poor nutrition; substance abuse; low levels of self-esteem due to social marginalisation, dislocation and oppression; excessive levels of stress; and, difficulties with integrating a healthy attitude towards the body, particularly in the area of sexuality.

The disease does not discriminate on the basis of social class and/or group affiliation, but does appear to affect the sexually active, and therefore potentially economically active, sections of the population. The AIDS pandemic therefore has economic implications and AIDS-related deaths will directly and indirectly affect the availability of both physical and mental health resources. Directly because several million infected persons will fill hospital beds while a vast number will require out-patient care. Indirectly because the budget for health services comes from taxable earnings. Moreover, in South Africa Kaposi's Sarcoma is less common than AIDS-related Tuberculosis and neurological deterioration, such as Delirium and Dementia. The latter are associated with cognitive, behavioural and motor symptoms (Dilley & Boccellari, 1989). This will have direct implications for underdeveloped mental health services.

HIV infection also appears to be more prevalent among socially marginalised people. Cochran & Mays (1989) note that women at highest risk for HIV infection in the USA are among the least advantaged groups in society: poor, urban ethnic minority women. Closer to home, Evian (cited in Jackson, 1994), an AIDS health care consultant, suggests that AIDS reflects the disparities in South African society in so much as those people who are dislocated in their society or community life are at higher risk. This would include communities in a state of transition such as informal settlements, migrants working away from home in unfavourable circumstances, and/or communities which are ravaged by violence and upheaval.

While in the USA the vast proportion of persons living with the virus are homosexual men and/or drug abusers, in Africa HIV is for the most part heterosexually transmitted. Given that the receptive partner is thirty percent more

vulnerable to infection (Jackson, 1994) women in South Africa will make up the larger proportion of persons with the virus. The AIDS pandemic therefore has profound social implications, in so much as the children of women in this situation stand a chance of themselves being infected. More mothers with HIV thus means more children infected by the virus, most of whom will not live beyond childhood and many of whom will themselves be abandoned.

## **Counselling the HIV-Positive Person**

Essentially HIV/AIDS counselling aims to support rather than transform the person living with the virus – it focuses upon the restoration of functioning to pre-existing levels of comfort rather than personality growth and change (Tartaglia, 1989). The latter, if it occurs, is regarded as a bonus rather than the focus of counselling. Counselling persons with HIV therefore aims to address the here and now rather than upon linking past issues with the present. Given this supportive rather than dynamic focus, it is critically important to distinguish between normal or spontaneous responses to a positive diagnosis and various transference issues evident in the relationship between counsellor and person with the virus. The former constitute reality-based concerns such as internal pressure to attend to unfinished business, reconciliation with alienated others; holding onto existing relationships, issues of self-esteem and identity, finding purpose and meaning in day-to-day activities, and where appropriate, preserving a sense of personal control.

Transference issues, on the other hand, whilst no less significant, reflect issues and expectations which have been displaced from a past source and are projected onto the present relationship. The immediacy of these “infantile prototypes” (Lapalanche & Pontalis, 1973) constitute the focus of more dynamic therapies. Thus, whilst transference issues certainly affect the level of empathy available in any helping relationship, they are not the focus of interaction between counsellor and person living with the virus and are important only in so far as they affect the counsellor’s willingness to be available as a support for the person with HIV.

### ***Reality Based Responses to HIV Infection***

AIDS is not only physically devastating – it is also emotionally and psychologically devastating. The person diagnosed HIV-positive experiences painful emotions associated with an acute existential crisis in the face of his/her death sentence, the possibility of new medical problems and continued debilitating illness and social isolation through multiple losses (Dilley & Boccellari, 1989). These responses can be considered normal responses to the threat of impending death

(Jackson, 1988) and the stigma associated with a sexually transmitted disease (Tartaglia, 1989).

Anxiety disorders are most frequently encountered among the uninfected at high risk (Goldblum & Moulton, 1989), but are relatively uncommon (Bialer, Wallack & Snyder, 1991), or virtually non-existent (Williams, Rabkin & Remien, 1991) among the infected. Where anxiety is manifest it tends to be a symptom of other psychiatric disorders (Bialer, et al, 1991), such as adjustment disorder with mixed emotional features (D'Anzi, 1987). The most common psychiatric disorders are mood disorders, particularly depression (D'Anzi, 1987; Tartaglia, 1989; Bialer, et al, 1991; Baker, 1993). This may range from a transient sadness to a full-blown major depression. Clinical depression can be induced in a number of ways. Firstly, it may be brought about directly by HIV infection or other viral/bacterial infections of the central nervous system, by tumours or strokes, or by abnormal functioning of the thyroid or adrenal glands (Baker, 1993). Where the central nervous system has been affected, the early stages would therefore include the classical signs and symptoms of depression and would progress to more neurologically malignant signs, such as mental disorientation, seizures, mutism, dementia and coma (D'Anzi, 1987; Dilley & Boccellari, 1989). Secondly, medical treatments with immune modulating agents can cause depression and sometimes mania (Baker, 1993) thus further exacerbating the existing organic mood disorder, while chronic and persistent use of recreational and escapist drugs may serve the same function.

Finally, there are a number of situational factors that compound a patient's existing mood disorder: the experience of living with a life-threatening disease; the stigma associated with HIV infection; the heartache of watching friends and family become ill and die; the torment of losing physical strength, memory, financial and vocational capability; and, increasing dependence on others as the illness progresses.

The person with HIV's experience of loss is therefore realistic on a wide variety of levels (D'Anzi, 1987; Jackson, 1988; Silven & Cardarola, 1989). There is the loss of a possible future in terms of establishing social support networks and an intimate relationship and/or family, as well as the loss associated with deteriorating physical and mental well-being. The person may also fear the loss of confidentiality, anonymity and privacy; and because AIDS is not well understood he/she may feel somewhat like a bug under a microscope, as being of value only as the object of medical and laboratory interest (D'Anzi, 1987). As such, a loss of human dignity is implied. In addition, the stigma associated with the disease is associated with a loss of self-esteem, while the person also suffers, like the uninfected, from the social and psychological ramifications of continual loss as friends, family and lovers succumb to the disease.

Persons receiving a positive diagnosis may experience all sorts of fears concerning disease, such as the possibility of disablement and disfigurement. Fears of death, the unknown, blame, stigmatisation, social isolation, rejection, financial difficulties, leaving dependents unprovided for and being unable to cope (D'Anzi, 1987) may also be experienced. Apprehension may accompany attempts to monitor the course of infection and status of the antibody and immune function (Tartaglia, 1989). Fear of becoming dependent upon others may also become an issue, since recurrent secondary infections leave the person with HIV/AIDS weak and eventually bedridden, and towards the end, often incontinent. Moreover, as the disease progresses the person becomes about as helpless as a new-born infant. While Aorki (1989) draws attention to cultural differences with respect to the need for autonomy, increased dependency is experienced as exceedingly difficult for those persons living with the virus who value their sense of independence and self-sufficiency.

Some persons may experience acute guilt at having contracted a sexually transmitted disease, perhaps from an extra-marital relationship. Guilt may also arise where the person thinks he/she may have inadvertently infected others, such as previous sexual partners and/or family members (D'Anzi, 1987; Jackson, 1988). Guilt may also be fed by pre-existing shame and guilt concerning sexuality (Tartaglia, 1989) and may be associated with attempts to withdraw from others and/or remain silent about infection.

Given the controversy surrounding HIV infection, many persons may also experience a great deal of confusion and uncertainty about what this means, while misunderstandings concerning the Western disease concept (Zazayokwe, undated) may exacerbate the existing confusion and uncertainty.

Finally, many persons infected by the virus may feel angry with themselves and/or various authorities, be they real or more mystical. Sometimes the anger will be redirected toward whomever is immediately available, thus constituting a transference reaction with respect to the caregiver or counsellor. At other times, the anger will be acted out on a personal or social level, such as rational suicide or when the person with HIV deliberately infects other people.

Whilst the list of possible responses above has focused on more negative and rehabilitating emotional and feeling states, there may also be an initial relief of anxiety when HIV infection is positively diagnosed when since previously inexplicable illnesses are clarified (Tartaglia, 1989).

### ***Transference Issues Associated with HIV Infection***

Tartaglia (1989, p. 172) observes that :

*"Patients with life-threatening diagnoses are subject to a powerful regressive force which will tend, at times, to make them regard themselves as childlike and often to behave accordingly".*

Tartaglia thus warns that persons with HIV are subject to strong transference responses. These responses present a problem in so much as they jeopardise the counsellor's ability and willingness to offer support as well as increase the chances that the counsellor will collude with these regressive and infantile responses.

The success of a therapeutic relationship is based upon trust, upon the establishment of a working alliance between the person with HIV and the counsellor. Due to previous unsuccessful involvement in the mental health system (Goldblum & Moulton, 1989) and an innate distrust of (Tartaglia, 1989) and refusal to put themselves at the establishment's mercy (Aorki, 1989), the socially marginalised person may experience difficulty trusting members of the establishment, such as mental health professionals.

Persons living with the virus may direct their anger at the counsellor, not only due to immediate frustrations, but also due to years of feeling oppressed for their cultural and/or class difference (Aorki, 1989), because the counsellor does not possess a magic cure (D'Anzi, 1987), and/or because the counsellor is not him/herself HIV-positive. The person may also direct anger against him/herself, such as in the instance of rational suicide (Jones & Dilley, 1993; Beckett & Shenson, 1993), at parents and friends for their detachment, distancing and lack of responsiveness (Silven & Cardarola, 1989), and at God for allowing the illness to occur (D'Anzi, 1987). Anger may also be directed toward the person who presumably infected him/her (Jackson, 1988).

On a more ideological level, Western society perpetuates the belief that bad things happen to bad people – that illness is a retribution for past transgressions (D'Anzi, 1987). Persons with HIV are thus often plagued by a sense of innate badness, of being contaminated and dirty – they internalise and appropriate the belief that they have got what they deserved (Silven & Cardarola, 1989) and this belief feeds both the person's anger at him/herself and his/her growing sense of isolation from others.

The sense of isolation is further exacerbated when persons who were previously available to support others with HIV/AIDS begin to distance themselves in preparation for the inevitable loss of life. This may lead to feelings of loneliness, expendability and rejection on the part of the person with HIV/AIDS (D'Anzi, 1987; Silven & Cardarola, 1989). Basic routines for infection control such as gloves further exacerbate the person's sense of isolation because the comfort of human touch and connection is lost (D'Anzi, 1987). While Shaw (1989) emphasises the importance of professional and personal boundaries when reaching out to

persons with HIV/AIDS, Tartaglia (1989) draws attention to the value of touch when contamination beliefs are present. He warns, however, that the reaching out should be neither patronising nor infantilising if the counsellor is not to collude with transference phenomena.

While fears of helplessness and dependence are realistic given the debilitating course of the disease, and should not be underestimated, Aorki (1989) also suggests that the intensity of such fears are culturally specific. Oriental and African cultures would seem to foster a sense of connection to the community, whereas in Western cultures individualism and independence are valued. For persons with HIV/AIDS who have been socialised according to Western values their sense of autonomy and independence is challenged as their physical and mental status deteriorates.

Finally, knowledge provides people with a sense of control (D'Anzi, 1987). For the person living with the virus, however, this belief and desire is challenged as a result of the many unknowns about AIDS, including the cause, the length of time still available to finish unfinished business and the possibility of a cure.

## Counselling Counsellors

Tartaglia's (1989) suggestion that counsellors should not get caught up in the transference issues of persons with HIV/AIDS provides the grounds for a discussion of countertransference responses, since awareness of such enables the counsellor to avoid feeding the patient's feelings of distrust and anger towards others, as well as his/her sense of internalised inferiority.

Countertransference, as an unconscious process involving a counsellor's unresolved conflicts in relation to his/her client, was first identified by Freud who viewed these feelings as an impediment to the treatment process. Heimann (1950) later reinterpreted countertransference to include all feelings experienced by the counsellor toward the client, and like Beitman (1983), viewed these feelings as useful for accessing the counsellor's unconscious complexes, for making diagnoses and for establishing intervention strategies.

For the purposes of this paper, Dunkel & Hatfield's (1986:115) definition of countertransference will be adopted. In other words, countertransference refers to:

*"...those conscious, preconscious, and unconscious responses and feelings of the (counsellor) that can be both a problem (with respect to establishing an empathic relationship with the infected person) and a valuable therapeutic and diagnostic tool."*

This definition suggests that the counsellor's capacity and willingness to understand and work through his/her own responses to the infected person's transference responses offers improved care to the infected person, as well as personal and professional development for the counsellor.

A variety of emotional issues may cloud a counsellor's judgment. In the first instance, the counsellor may suffer from a wide variety of fears. Perhaps most difficult to deal with is his/her fear of death and dying which increases in the presence of persons with HIV/AIDS (D'Anzi, 1989; Dunkel & Hatfield, 1986), as if death too might be contagious. Working with a dying patient therefore challenges the counsellor's own unresolved feelings with respect to his/her mortality.

A critical requirement for working with those living with HIV/AIDS is the counsellor's availability, reliability, empathy and ability to respond emotionally to the person (Tartaglia, 1989). The counsellor, in his/her attempt to preserve and protect him/herself from experiencing the pain of loss or death of another may attempt to distance him/herself from the person. On a psychological level, this blocks the possibility for empathy, since the counsellor fails to acknowledge that this illness involves a major psychological and emotional component. On a physical level, the superficial social conventions of greeting and exchanging pleasantries is allowed, but without the substantive confirming human touch. The counsellor's need to psychologically and physically distance him/herself from the person with HIV/AIDS can thus result in the counsellor denying the personhood of the individual and the person reducing the number of contacts with the counsellor.

In the second instance, medical science places a high priority on beating death (D'Anzi, 1987; Chopra, 1991). While this may be helpful for instilling hope in an effort to treat the syndrome, the counsellor's denial of his/her fundamental helplessness often engenders a situation in which he/she tries to gain control of the situation through a magical belief in his/her own omnipotence. When this fails, ie the person succumbs to the disease, the counsellor may experience a sense of helplessness, personal failure and guilt (Shaw, 1989), and ultimately refuse to treat those who are HIV-infected.

Anger and frustration may also be experienced by the counsellor when despite his/her best intentions the person's condition continues to deteriorate (D'Anzi, 1989), as it inevitably will. In order to defend against these feelings the counsellor may attempt to blame the victim (Dunkel & Hatfield, 1986; Shaw, 1989) in an unconscious attempt to punish the person with AIDS. Blaming the victim, when combined with unconscious hostility and a fear of contagion, may also take the form of distancing, either physically or psychologically, and thus further exacerbate the person's sense of isolation.

A great deal of uncertainty exists with respect to the course and treatment of the disease. At the same time, the medical practitioner is expected to make major medical decisions. For instance, does he/she treat with AZT when AZT itself suppresses the immune system? Does he/she put a profoundly depressed person on a full therapeutic dose of anti-depressant medication while simultaneously attempting to monitor the person's mental status? Uncertainty about the disease thus

also exacerbates the practitioner's fears of professional inadequacy (Shaw, 1989). Moreover, the person with HIV/AIDS may also very often know more about AIDS than does the counsellor. This may threaten the power base of the relationship between counsellor and person, since it further challenges the counsellor's claim to professional adequacy. Treating persons with HIV/AIDS thus demands a willingness to learn from and share information with them, and thus develop a relationship of mutuality rather than power, since AIDS is an incurable illness and cannot be beaten. The emphasis in counselling thus rests upon exploring the meaning of the symptom for the person living with the virus, rather than debating the possibility of a cure.

In the third instance AIDS is, for the most part, a sexually transmitted disease. Discomfort with sex, sexuality and sexual behaviour (Shaw, 1989) may threaten the level of empathy available to the person with HIV/AIDS, since as Shernoff (1989:76) observes: "*...the majority of mental health professionals have received relatively little or no training in human sexuality or sexuality counselling*". HIV infection, however, brings sexuality into sharp focus. This can be uncomfortable for both person and counsellor where the former feels intruded upon or angered by discussion of safer sex and/or interprets the counsellor's discussions about sexuality as a negative parental injunction. Moreover, whether conscious or unconsciously, the counsellor's disapproval and hostility towards the presumed promiscuous lifestyle and/or sexual orientation of the person is perceived with exquisite sensitivity (D'Anzi, 1987). A judgmental attitude undermines the person's trust of the counsellor, and thus the efficacy of both the support and the advice offered. It is therefore critically important that the counsellor maintain his/her sense of neutrality with respect to the person with HIV/AIDS' sexual orientation and/or behaviour, since professional neutrality concerning these issues leads to generalised trust and the breakdown of social isolation (Tartaglia, 1989) and this tends to remedy the person's sense of internalised inferiority and badness.

In the fourth instance, despite relative certainty concerning how HIV is transmitted, namely by means of body fluids, even the trained counsellor may suffer from irrational and hysterical fears of contagion (Dunkel & Hatfield, 1986; D'Anzi, 1987; Shaw, 1989). In some instances the population, as exemplified by one person, easily takes on the status of the 'other' and detachment replaces the process of empathy (Dunkel & Hatfield, 1986). The counsellor's fear of contagion therefore colludes with the person's belief that he/she is untouchable.

Finally, inherent in the empathic process is the ability to feel with the person. Identification with the person living with HIV/AIDS is therefore a necessary part of the therapeutic process and relationship (Dunkel & Hatfield, 1986; Silven & Cardarola, 1989). Over-identification, however, occurs when the counsellor's ability to return to an autonomous stance is lost. This can result in the counsellor

investing unrealistic amounts of time and/or energy in the person, or in familiarising him/herself with the literature. In extreme instances, over-identification results in burn-out.

## **Counselling Survivors**

Given the predicted escalation of the AIDS pandemic and the apparent limited availability of formal health care services the care and support of persons with HIV/AIDS will need to move beyond the support that can be offered by trained health professionals. In other words, the community at large (partners, family and friends) will need to take increasing responsibility for their care. Involvement by the wider community, however, has multiple implications for the general well-being of the population.

In the first instance, the stress and fatigue of caring for persons living with HIV/AIDS will need to be addressed, since as Weiss (1989:272) observes:

*“The work required to keep the dying person fed, clean, and medicated appropriately along with the emotional strain and disruption of usual life activities can be overwhelming”.*

At the same time, the caregiver may feel guilty about not doing more for the person with HIV/AIDS and blame themselves for having their own personal needs. It is likely therefore that counsellors will be called to counsel the person's caregivers, particularly with respect to their limitations. In addition, counsellors will need to assist caregivers in reducing their level of guilt when caregiving is no longer possible. This suggests that the counselling of persons with HIV/AIDS's caregiving networks is an important intervention strategy for the future.

Losing a significant other to death is considered one of the most stressful events in a person's life (Weiss, 1989) and presents survivors with multiple challenges. The loss of a significant other to death not only confronts the survivor with his/her own human mortality, but also fragments his/her attempts to self-regulate (Kast, 1990). Initially the individual in mourning experiences shock at the loss a significant other. This is accompanied by a tendency to focus upon the absence of the significant other rather than upon the presence of surviving others. At this point the survivor withdraws from the world and the support of others in order to reorganise and reintegrate his/her sense of self. If successful, the survivor re-enters the world of others.

The predicted prevalence of HIV/AIDS-related deaths in the future suggests that a substantial proportion of our society will be working through a mourning process, ie will be attempting to reconstitute their lives without the physical

presence of significant others upon whom they depended for their sense of self. While it is presumed that most persons are capable of working through the mourning process without professional intervention, a substantial proportion of the population are likely to suffer from complicated and delayed grief reactions triggered by new and continuous losses.

The mourning and bereavement process associated with an AIDS-related death is further complicated by the stigma associated with infection since it draws attention to a number of cultural taboos, most primarily human sexuality (Zazayokwe, undated). This may inhibit survivors' attempts to re-enter the world of others. In addition, fears of rejection, survivors' worry about their own health status and, if infected, the anticipated loss of their own health, further complicates the bereavement process. It is possible, therefore, that a substantial proportion of our population will suffer from complicated grief reactions characterised by depression and/or phobic responses. The latter may be directed towards surviving persons with HIV/AIDS and thus further reduce the amount of support available.

## Discussion

There is no doubt that individuals' self-management of their sexual behaviour is the key to preventing HIV transmission (Shaw, 1989). For the most part, however, educational programmes for the promotion of safe sex have proven ineffective (Odets, 1993) due to the use of rational cognitive strategies for the control of what is essentially a passionate form of human expression. In addition, the initial tendency to phrase risk for HIV infection in terms of risk groups rather than risk behaviours has facilitated individuals' tendency to deny their personal risk of infection since if the individual does not belong to an identified 'risk group' he/she defensively believes that he/she is invulnerable to infection (Isaacs & McKendrick, 1992). Safer sex educational strategies for the prevention of HIV infection are therefore likely to have only a limited impact on the pandemic's escalation.

The likelihood that various co-factors contribute towards susceptibility to HIV infection provides a second possible level of intervention. Such intervention strategies would need to include a wide variety of practical educational programmes which attend to, *inter alia*, nutritional issues, drug use/abuse issues and the meaning of illness. Nutritional programmes, however, would need to be both culturally sensitive and practical, in the sense that they include creative and constructive agricultural methods and practice. Drug education programmes may also be relevant given that increased levels of toxicity and immune system suppression are associated with imbibing nitrate-based substances (Duesberg cited in Guccione, 1993), while drug use/abuse also contributes to less responsible

attitudes towards safer sex. Education programmes aimed towards the reclamation and care of the body, and particularly human sexual functioning, may also prove particularly helpful, since as Kast (1990) suggests, the initial purpose of every illness is that we pay more attention our the body. HIV infection and the threat of imminent AIDS symptoms and secondary infections thus challenges persons with the virus to pay more attention to their corporeal existence. And, given that every symptom is an embodied symbol (Kast, 1990) or metaphor (Romanyshyan, 1975) the prevalence, risk and manner of transmitting HIV infection challenges us to look toward the manner in which we relate to our sexuality – a phenomenon that also inevitably involves the manner in which we relate to each other as sexual beings.

Culturally influenced attitudes to death, illness and sexuality (Aorki, 1989; Zazayokwe, undated), and the changing demographic nature of the groups affected by HIV, suggests that educational interventions would need to be both culturally sensitive (Aorki, 1989) and designed specifically for each population (Dilley, Pies & Helquist, 1989). Among African populations, for instance, body care programmes may need to focus upon access to nourishment (which for a wide variety of historical, economic and political reasons has been limited), whereas among Western populations the opposition and split between mind and body may need to be addressed. In other words, body care programmes would need to focus upon the ideologies underlying each population's view of corporeal existence and its demands.

The development and efficacy of any of these proposed interventions above rests, however, upon our willingness to face the reality of our human and historical situation. The existential truth of the human condition, and our only certainty, is that human being is finite: we grow old and die. Moreover, right now hundreds of thousands of people are infected and the infection rate promises to increase in the foreseeable future. The most appropriate intervention strategies are thus those directed towards dealing with rather than preventing the transmission of HIV. This inevitably involves concerted efforts to involve the community in the care of the dying and the timeous teaching of caregiving and counselling skills to individuals within these communities. Such training would need to include information concerning the pressing reality-based concerns of the individual living with HIV, as well as knowledge about the various transference and countertransference responses that serve to complicate the counsellor and caregivers' availability and willingness to care.

It is, in the first instance, critically important to both clarify and work through the reality-based responses following a positive diagnosis. These include feelings of loss, fear, guilt, confusion and anger. At the same time, the prevalence of psychiatric disorders associated with HIV infection, and the ambiguity around these disorders' organic and/or functional status, suggests that it is also crucial that

counsellors avoid dismissing depressive symptoms as understandable responses to the stresses the person with HIV endures and refer for medical and psychiatric help where appropriate.

Transference refers to those conscious, preconscious and unconscious feelings and responses that the person with HIV feels and expresses in the presence of, and towards, the counsellor. These responses may be based upon distrust of the establishment, anger at authority figures and experts who fail to cure the disease and an internalised sense of inferiority. With respect to the latter, persons with HIV may presume themselves to be an untouchable caste who are denied human comfort and connection, and depending upon cultural factors, many may also resent their loss of independence, autonomy and control over their lives. To inadvertently collude with these beliefs, says Tartaglia (1989), reinforces the person with HIV/AIDS's sense of helplessness and thus undermines their adult sense of identity and self-esteem. It is critically important, therefore, that the counsellor relates to the person in a manner that re-establishes and maintains the his/her sense of human dignity.

Failure in counselling relationships occur for two reasons: ignorance on the part of the counsellor (Kohut, 1971), which is correctable by further training; and failure to recognise and properly utilise countertransference responses (Langs, 1978). Given the highly emotional nature of the work with persons living with HIV/AIDS, it is unavoidable that the counsellor's biases will emerge and rigidify in reaction to the threat confronting the person (Aorki, 1989). This makes the work both highly challenging and rewarding, since the counsellor's own dynamics are illuminated through the process. At the same time, such responses can lead to burnout for the counsellor. It is thus critically important, as Shaw (1989:274) observes, that:

*"...mental health providers...acknowledge their own concerns in order to identify and correct those factors which...interfere with their work with...clients."*

Counselling thus not only requires a balance between overreacting to transference issues and under-reacting to reality-based issues, but also requires that the counsellor deal with his/her personal responses and attitudes towards persons with HIV/AIDS. Moreover, the tremendous ambiguity that must be faced in working with persons with this condition, as well as what constitutes an appropriate therapeutic approach, provides fertile ground for the generation of further countertransference issues. Thus, while a basis for empathy (Peabody & Gelso, 1989), countertransference responses may also jeopardise the counselling relationship. This suggests that counsellors need to be trained to examine their own attitudes to the issues involved, to acknowledge the uncertainty of the situation, and

to recognise the limits of their expertise and refer appropriately. This would serve to both develop the counsellor and ensure that he/she creates an accepting and healing, rather than defensive and persecutory, space for the person living with HIV/AIDS.

Several more pragmatic measures also need to be considered with respect to counselling. In the first instance, treating persons with HIV/AIDS demands a team approach, not only because AIDS is a physical disease that requires careful monitoring and medication, but because it is also a behaviourally transmitted disease with severe emotional and psychological consequences. Moreover, and in terms of caring for the counsellor, the team approach provides both a potential source of support for the counsellor and an opportunity for co-supervision, or a safe space in which counsellors' areas of vulnerability can be identified and worked through constructively. Counsellors also require continued updated clinical and scientific information in order to provide quality care. A team approach thus also presents a forum for debating and assisting each other's understanding of the complex issues.

Finally, the counselling of caregivers also requires that the limits to which caregivers can be expected to prevent the death of persons with AIDS and their guilt for not having done so be addressed. In addition, the likelihood of delayed and complicated grief reactions due to continual and repetitive losses and the stigma associated with caring for a significant other with a sexually transmitted disease will also need to be addressed if the general wellbeing of the broader population is to be maintained.

## **Conclusions: Challenge or Crisis**

The prevalence of the AIDS pandemic and its various social and economic implications suggests that South African society as a whole will be profoundly affected by the disease, particularly that group of people invested with responsibility of reproducing the nation, namely women.

The expected pressure on both primary and secondary health care services implies that both professional and lay persons will be called to treat and support persons with HIV/AIDS, while at the same time being expected to cope with their own inevitable sense of loss; for it is unlikely that anyone will escape the passing of either close friends and/or family members. Moreover, and in view of the medical professions' apparent helplessness with respect to securing a cure for HIV infection and/or AIDS, and the controversy surrounding the HIV-AIDS link, it would seem that prevention and treatment strategies will need to focus upon co-factors associated with susceptibility to infection, and more specifically upon the counselling of persons with the illness, their counsellors, and the family and friends who care for and survive the person's death.

Accompanying a person on their journey to the edge of the abyss, or death, is always difficult and challenging, for it confronts us with our own human mortality. A counsellor's understanding of how the person responds to his/her own challenge, in terms of both his/her normal and transference responses, enables deeper empathy. It also enables the counsellor to allow the infected person his/her natural responses and the opportunity to reality test his/her notion of inferiority and untouchability.

Failure in counselling occurs where the counsellor has not been made aware of and trained to deal with his/her own countertransference issues. A counsellor's understanding of how he/she responds to the person with HIV/AIDS, in terms of the ambiguities and prejudice surrounding infection, the limits of his/her expertise and the inevitable loss of the patient to death is thus critical. It allows the counsellor to examine and understand where the empathic relationship is jeopardised by his/her own natural responses and to remedy the relationship through self-correction. The willingness to self-examine these responses not only promotes efficacious care but personal development for the counsellor. It also serves to prevent counsellor burn-out and/or withdrawal from caregiving.

On a broader social level, the loss of a significant other initiates a mourning process, which if it proceeds normally enables the person to reintegrate and reenter the community with a renewed sense of autonomy. A particular danger with respect to the AIDS pandemic, however, is that continual and repetitive losses leave survivors trapped in their grief, and thus either depressed or alternatively isolated, in so much as they avoid contact with surviving persons with HIV/AIDS.

As Weiss (1989:274) suggests, however:

*"Healing the pain of secrecy and isolation comes from reinvolverment in the community, either as a helper, volunteer, professional, or recipient of services."*

This wisdom holds true not only for the isolated person who believes he/she is untouchable and contaminated but also for survivors of AIDS-related deaths. In other words, the pandemic offers opportunities for rebuilding and reintegrating South Africa's shattered community of communities – it is a call to reach out to others with renewed compassion and understanding of our shared humanity.

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