PASTORAL DEVELOPMENT TRAINING IN CONTEXTUAL AND NARRATIVE FAMILY THERAPY

by

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DECLARATION

Submitted in fulfilment / partial fulfilment of the requirements for the degree of
Doctor of Philosophy , in the Graduate Programme in Social Work
University of KwaZulu-Natal,
South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. I confirm that an external editor was / was not used (delete whichever is applicable) and that my Supervisor was informed of the identity and details of my editor.
It is being submitted for the degree of Doctor of Philosophy in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

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Editor

TABLE OF CONTENTS

CHAPTER 4: LITERATURE REVIEW: TRAINING AND ASSESSMENT

134

List of Tables

List of Figures

Abbreviations

ABDCE model: Action, Background, Development, Climax, Ending (Anne Lamott 1995). (developed from Alice Adam's formula for fiction writing).

AIC: African Initiated Churches. Within the AIC a distinction is made between:

- African Independent Churches, which originated in Africa, and are not linked to groups or churches outside of Africa for any form of support

- African Initiated Churches, which originated in Africa, but may have affiliations outside of Africa.

- African Indigenous Churches, which exclusively hold to African ethics, culture and theology.

- African Instituted Churches, which were established and developed in Africa (Hayes 1998 in Maimela & Konig).

AIDS: Acquired Immune Deficiency Syndrome (or Aids: Acquired Immunodeficiency Syndrome)

ANC: African National Congress

ART: Anti-Retroviral Therapy

ARV: Anti- RetroViral

CABSA: The Christian AIDS Bureau for Southern Africa

CPSA : The Anglican Church of the Province of South Africa

CPE: Clinical Pastoral Education movement

COPES Format: Client Oriented, Practical Evidence Search

CRC: Culturally Relative Curriculum

DR & U: Thomas's Developmental Research and Utilisation model (1981).

DVD: Digital Versatile Disc or Digital Video Disc

EBL: Evidence Based Learning

EBP: Evidence Based Practice

EHAIA : Ecumenical HIV/AIDS Initiative in Africa

EST: Empirically Supported Treatments

FBO: Faith Based Organization

FGD: Focus Group Discussion

Grid: Gay Related Immuno-Deficiency

HIV: Human Immunodeficiency Virus

IQ: Intelligence Quotient

IRM: Intervention Research Model

ISD: Instructional System Design

M&E: Monitoring & Evaluation

NGO: Non-Government Organisation

NQF: National Qualifications Framework

OADP: Okahlamba Area Development Programme

OBE: Outcome Based Education

PBL: Problem Based Learning

PICO Format: Population, Intervention of interest, Comparison intervention or status, Outcome

RCT: randomized clinical trials

SACC: South African Council of Churches

SAHARA: Social Aspects of HIV/AIDS & Health Research Alliance

SAQA: South African Qualifications Authority

Social R & D: Rothman's Social Research and Development (1980).

STD: Sexually Transmitted Disease

Swapol: Swaziland Positive Living

TB: Tuberculosis

TEASA: The Evangelical Alliance of South Africa

UCCSA: United Congregational Church of Southern Africa

UNAIDS: The Joint United Nations Programme on HIV/AIDS

UPCSA : Uniting Presbyterian Church of Southern Africa

URDR: Unit for Religious Demographic Research in the Department of Practical Theology and Missiology at the University of Stellenbosch.

USA: United States of America

VCT: Voluntary Counselling & Testing

WHO: World Health Organisation

WCC: World Council of Churches

ACKNOWLEDGEMENTS

ABSTRACT

The need for a family therapeutic counselling programme in the management of HIV/AIDS was established by the researcher in 2001 (den Hollander 2001). The focus of this study was to develop the training programme model in family therapeutic counselling for church leaders and lay counsellors. This was accomplished using a variety of samples and research instruments, by firstly exploring the issues and problems facing people and families living with HIV/AIDS and then how best churches could respond as faith-based community organizations.

At a theoretical level, this study sought to compare the paradigms of contextual and narrative family therapy with the theory and practice of social work and practical narrative theology, in order to integrate these paradigms into an incorporated response to the HIV/AIDS pandemic.

The main research methodology was the Intervention Research Model as adapted from De Vos (2001). This model consists of six phases, consisting of problem analysis and project planning, information gathering and synthesis, design, early development and pilot testing, evaluation and advanced development, and dissemination of the training model. During the analysis phase an extensive literature research, as well as several field studies, both quantitative and qualitative were conducted. During the development phase, three pilot studies were designed and performed, in attempt to accommodate the context specific problems of different families and communities.

The results of these two phases indicated a need for pastoral training in family therapeutic counselling, specifically in the areas of mental health, trauma and bereavement and child participation. Importantly, the need to intervene meaningfully to alleviate structural problems such as poverty and food insecurity were clearly indicated, with the study recommendation being for active networking across all stakeholders so that therapeutic counselling may work in tandem with these community based efforts.

Recommendations in respect of offering such training are to provide a comprehensive structure of training, supervision and counselling practice.

CHAPTER ONE

INTRODUCTION

This study is concerned with the development of a training model in contextual and narrative family therapy for church leaders and lay counsellors, in the context of their pastoral counselling work with HIV-affected families and communities in Southern Africa.

The rationale for this topic was motivated by the researcher's previous study at a masters level where the value of contextual and narrative family therapy approaches was established for use with HIV/AIDS-affected persons (Den Hollander 2001). Since services to HIV/AIDS affected persons are offered by many role players, not the least of which are church-based bodies, the researcher considered it desirable to examine how lay counsellors could be promoted to offer services using these theoretical stances.

In pursuing the goal of establishing a training model, the researcher also undertook the following functions:

- ➢ Exploring the issues and problems facing people and families living with HIV/AIDS and the role of churches as responsive faith-based community organisations.
- ➢ Comparing the paradigms of social constructionism and post foundationalism as relevant to contextual- and narrative family therapy, community social work, and practical narrative theology in order to integrate these paradigms into an incorporated response to the HIV/AIDS pandemic.

➤ Describing current training models in family therapy, with a specific focus on pastoral counselling and HIV/AIDS related psycho-social problems.

➤ Using all these data to arrive at a best practice model in pastoral family therapeutic counselling training for Southern Africa.

1.1   <u>CONTEXT OF THE STUDY</u>

Southern Africa is recognized as the epicentre of the AIDS pandemic. Sub Saharan Africa remains the region most heavily affected by HIV/AIDS. In 2007 there were 22 million people living with HIV of which 1.9 million were newly infected. They account for 67% of all people living with HIV and for 75% of all AIDS deaths in 2007. The UNAIDS data for 2007 reflect that an estimated 5.7 million people were living with HIV in South Africa, with an HIV prevalence percent of 18.1 % for the 15-49 age group. In 2007 the number of AIDS deaths in adults and children was estimated as 350 000 for South Africa (UNAIDS 2008). In Southern Africa, families and communities are both directly and indirectly affected by the HIV/AIDS pandemic, for example, by living with HIV-infected family members, working with HIV-infected colleagues, worshipping with or caring for HIV-infected church members, providing antiretroviral treatment adherence support, burying family members and neighbours who died of AIDS, taking care of their offspring, or just by reading about it in the paper. Families become affected when the 'normal' family life cycle has been dramatically changed, when illness, grief and death become part of everyday life, when young people die 'before their time' and when people living with HIV/AIDS, their family members and specifically their children are not heard, and their emotional and relational needs are not met.

The researcher agrees with Barnett & Whiteside, that the HIV/AIDS pandemic affects the health of individuals as well as the well-being of households and the social welfare and development of communities (Barnett & Whiteside 2002).

The complex circles of reciprocal influence regarding HIV/AIDS clearly cut across the individual, family, community and nation. Many HIV-infected people are still excluded from access to antiretroviral therapy and are left with treatment options dealing more with symptom relief than with the underlying cause of the disease. The roll-out programmes of antiretroviral treatment at African clinics and hospitals has brought improved health, but also the challenge of adapting to a regular and healthy lifestyle. The challenges experienced in living with and supporting an HIV positive partner, family, or community member in need of adherence counselling and ongoing support emphasizes even more the need for a well structured, comprehensive therapeutic counselling and support programme. Clearly, successful treatment and management of HIV-positive persons is a multi-various affair, with this study searching for problem-laden stories that will suggest where and how, best practice should prevail.

Another development of note in identifying the context of this study is recent research and reports on community practices that include faith-based organisations. The UNAIDS 2005 survey on community best practice mentioned the growing role of community-based organisations in HIV care and treatment provision, including faith-based community organisations, for example, by supplementing or replacing the public sector services, and by spreading their models of care to local hospitals. Some of the activities that organisations are involved in are: Information campaigns, counselling, psycho-social support, support groups, income-generating schemes, training, providing access to treatment, and adherence support. People living with HIV are helped to overcome denial and stigma, optimize the use of their resources, and sustain their positive participation. The report mentioned diversity and complementary services as one of the greatest strengths of the community based response, involving different skills, vocations and resource bases. The role of community networks was highlighted as providing a pool of efforts and resources (UNAIDS 2005). This study report highlights the need for community based activities that support a therapeutic counselling service. The researcher believes that the study

focus being located in the community, with a target of several role players from the community, will offer rich data that may be context and community-specific in offering relief to HIV-affected persons. Granted, there will be and needs to be multi-various ways of managing the pandemic (Kasiram 2009). But for the purposes of this study, the focus will be on the aspect of therapeutic counselling and service in communities (Den Hollander 2001).The wide reach of the pandemic is not to be ignored in offering the context of the study. Parker et al (2000) described HIV/AIDS as not only a medical problem, but also as a social problem, with complex contextual implications and consequences. They mention factors such as poverty, illiteracy, urbanization and gender relations. They propose an integrated strategy, in terms of HIV/AIDS prevention and support, which needs to be dialogue-orientated and participatory. The sharing of meaning and interpersonal communication is emphasized as is the use of familiar communication systems (Parker et al 2000). The present study will focus on dialoguing with community members in order to accommodate the wide reach of the pandemic, in an effort to arrive at best practice options in the area of therapeutic counselling. Tangwa calls for a re-appraisal and re-evaluation of traditional African communitarian values, knowledge systems and practices; for example, empathy, unpaid assistance and mobilization of immediate community resources (Tangwa 2005). By engaging with several different communities that will include traditional communities, rich narratives containing communitarian values and the like will be uncovered in the study. These will be included in contributing to building a community and thus context-sensitive training model.

A mapping study prepared for the World Council of Churches on responses of the South African churches to HIV and AIDS mentioned that churches have credibility and are respected in the community (Parry 2005). Hence the focus of the study is to develop a training programme that may be used by church and lay counsellors. A truly effective response to the devastating impact on the lives of South Africans would take extraordinary commitment, strong leadership and courageous vision. The study explored and described community faith-based

initiatives in the areas of HIV/AIDS prevention, care and counselling together with examining how some training institutions integrated HIV/AIDS into their curriculum (Parry 2005). Parry's recommendations mention a lack of key competencies in areas including leadership, skilled counselling, communication on sexuality, responsible fatherhood and the care of orphans. Mention is made that programmes have human capacity challenges, of people living with HIV being insufficiently involved in the life of their churches and stigma and discrimination that are still very evident. Partnerships and networks with other faith groups, non-governmental organizations and the private sector are being put into place and faith-based organizations are seen to have flexibility and ability to respond to the needs of the people. However, greater collaboration is recommended in order to better the infrastructure of service provision, shared resources and to maximize coverage (Parry 2005). The study responds to the need for involving church and faith-based initiatives and in doing so, encourages feasible partnering with them. By promoting and improving their service offerings in respect of HIV-affected persons, through the conduct of this study, these partnerships may be consolidated.

Church-based initiatives are already in existence and will be reviewed during the conduct of this study. Several denominations in Africa have put HIV/AIDS policies and programmes in place and developed structures to translate and apply these policies and programmes to churches at local community level. One such case is the African Religious Health Assets Programme that studied the contributions of religious communities to health care, and their way of confronting and combating the threat of HIV/AIDS. The focus was on programmes which strengthen the healing energies in people and society and appreciate the social impact of religion on public health. The social impact is understood as a religious worldview of deep-seated desires, fears, expectations, memories and wisdom (Cochrane 2005). Such data will be useful in compiling the final training programme.

An important context to consider is researcher experience, mentioned as providing some motivation to undertake this particular research topic. The researcher also experienced in the HIV/AIDS pastoral counselling training of church leaders and lay counsellors, that there is an expressed need for counsellors to reflect on their faith, values, culture and community practice in order to become more empowered and competent in leading their churches in helping families living with HIV/AIDS. Such a personal experience lends credibility to appreciating Cochrane's (2005) suggestion for uncovering deep-seated desires and world views that influence counselling, and will be discussed in the analysis of findings in this report/study.

1.2   MOTIVATION FOR THE STUDY

Research is clearly often motivated by personal experience as mentioned and this study is no different.

In her former practice as senior medical social worker at McCord Hospital in Durban, the researcher found that families living with HIV/AIDS are in need of successful and meaningful prevention and care services in the community, whilst addressing their physical, emotional, spiritual and economical needs. Families living with HIV/AIDS are at risk of becoming more infected and affected if their needs are not met in ways that involve the family as a whole and are empowering by nature. This study aims to understand how best to intervene to involve and empower the family.

In her current position as manager of the Siyahlanganisa Centre for Leadership Training and Pastoral Development, the researcher and her team had the following experiences that further motivated the study:

➢ Providing training to over 7000 church leaders and lay counsellors with a comprehensive programme in HIV/AIDS pastoral care and counselling

skills showed up gaps and strengths. As a training outcome, church-based support teams were formed, and involved themselves with community counselling and project development for families living with HIV/AIDS. This development served to peak the researcher's interest in studying how such support teams may enhance and/or complement services to families.

➤ Further training was developed, when aspects of care and counselling needed more emphasis; for example, training in care for orphans and vulnerable children and home visitation skills, which cover aspects such as stigma, antiretroviral drug adherence and granny- and child-headed households. The experience demonstrated that gaps existed for special needs groups and problems such as these.

➤ From the trainees has come a request for a more specialized training programme in working with families with HIV/AIDS. Basic counselling skills do not seem to be sufficient in dealing with the complexity of family relationship problems. In addition community health workers and pastoral counsellors, who visit families with HIV/AIDS at home, have expressed the need for affordable and accessible referral options in dealing with intergenerational family problems and challenges.

➤ The training programme accessed educators' views from Bible Colleges. They together with church leaders in several communities have shown interest in further training related to family preservation, relational ethics and community leadership. The need of theological students and more senior church leaders for a comprehensive and ongoing learning programme, commencing at undergraduate level and progressing to postgraduate studies was apparent.

A further motivation fuelling this study relates to the significant amount of HIV/AIDS research that in Africa has been produced in the field of social science. The Social Aspects of HIV/AIDS & Health Research Alliance (SAHARA) specifically focused on the social aspects of HIV/AIDS and health (4th SAHARA Conference 2007). Through her experience with the training programme the

researcher discovered the need for church leaders to be updated about recent research findings, both in the fields of theology and social science, to be trained in dissemination of information, and to become involved in research projects. This study fulfils the need for active engagement with church and faith-based organisations.

Last but not least, in her master's thesis on family therapy and families with AIDS (Den Hollander 2001), the researcher described different approaches to family therapy and used contextual family therapy as developed by Boszormenyi-Nagy with a family living with HIV/AIDS. Her recommendation was to design a training programme in contextual family therapy for community counsellors. The researcher has since realized the need for broadening the approach to include narrative family therapeutic skills for families with HIV/AIDS as developed and described within the context of practical narrative theology in Southern Africa. Hence the title, subject and scope of the present study.

1.3   EXPLANATION OF KEY CONCEPTS AS USED IN THE STUDY

1.3.1   Families

The term "family" is used extensively in this study. It will therefore be fully explained in relation to its use in the study.

Mturi and Nzimande (2006) mention the family as the primary institution of society; they believe that at the family level, basic functions in a society are performed. They describe family as any combination of two or more persons, who are bound together by ties of mutual consent, birth and/or adoption or placement and who, together, assume responsibility for the care and maintenance of members, the addition of new members through procreation or adoption, the socialization of children and the social control of members (Mturi & Nzimande 2006). This inclusion applies to the study.

Waruta mentions that the concept of family should be defined in African terms, as embracing a wider community of more than two persons coming together, according to an approved social pattern whereby they establish a family (Waruta 2000). This concept of family as community is embraced in the study, as it provides the context wherein the family is properly appreciated and understood.

Balswick et al, identify stable and strong families as families who practice covenant love, which will manifest through grace, empowering and intimacy. The family is also seen as the cornerstone of moral order in society (Balswick & Balswick 1999). This definition is also incorporated in the study, by dialoguing at a deeper level with participants to uncover how values and moral positions influence family and community perceptions and counselling practices.

Browning and Rodriguez (2002) defined families as some arrangement whereby one or more adults – by either biological procreation, legal action, or other circumstances – have assumed the central responsibility for raising children. This position is clear and constitutes the traditional understanding of family that is also adopted in the study.

Parry and Doan (1994:19) identify the contemporary family as:

> "…a crossroads, more than a self-contained system; in it a minimum of two generations and two genders come together, depending on one another more than the members often care to admit, even though the generations and the genders more and more frequently inhabit different worlds and speak bafflingly different languages."

This definition is also adopted in the study, particularly the aspect of members in families "inhabiting" different worlds which is often part of the ostracism experienced by the person living with HIV/AIDS.

In this study the researcher mentions/uses a variety of definitions of 'the family', embedded in different philosophical paradigms and relating to different cultural

practices. Families are identified as 'primary institutions', 'wider communities', 'cornerstones of moral order', 'some arrangement' or contemporarily, 'crossroads'.

1.3.2   Family Therapy

"*Family therapy can be conceptualized as a frame of reference that emphasizes the interconnectedness of all stories, and that is informed by this notion as we attempt to interact with clients in a useful way*" (Parry & Doan 1994:49).

In this study the *interconnectedness of all stories* is central, relating to the stories of marginalized families living with HIV/AIDS, the co-researchers, the churches in community and each individual bringing their personal story, including the researcher.

1.3.3 Contextual Family Therapy

Den Hollander (2001) identifies contextual family therapy as a comprehensive approach to working with families, which allows for the inclusion of other therapeutic approaches and addresses the four interlocking dimensions of (1) facts, (2) individual psychology, (3) behavioural transactions and (4) relational ethics. Interventions are aimed at personal healing and symptom relief as well as addressing relational and intergenerational problems. Contextual therapy focuses on ethical issues in relationships, such as trust and fairness and the multilateral process of achieving an equitable balance of fairness among family members. Contextual therapy seems relevant to the South African context, where it recognizes the history of social injustice playing an important role in the family's review of debts and entitlements. Contextual therapy mentions the resources of care, concern and connection as the family's "own immune system" and uses the term "distributive justice" for the allocation of the family's resources and availability of resources in the community. Loyalty and intimacy are viewed as resources of relationships. Exploitation, split-loyalty, parentification, and other dysfunctional patterns are discussed in relational ethical terms. Therapeutic

intervention would result in the relational resource of self-validation which family members receive through giving or caring. Dealing with realistic guilt (a core concern with HIV-affected persons) becomes a relational resource whereby family members become more accountable and trustworthy. Relational resources provide healthy functioning for both current and future generations and therapeutic intervention is therefore aimed at prevention (Boszormenyi-Nagy in Gurman & Kniskern 1991).

In this study contextual family therapy is used because of its relevance to the life world of families living with HIV/AIDS, its interpersonal and intergenerational approach, and its unique focus on the relational ethical dimension.

1.3.4 Narrative Family Therapy

Narrative family therapy provides an individual, group and community approach to family therapy, embracing a multi-dimensional stance that is generally advocated in community family therapy (Kasiram 2009). The training programme in the study will target community based counsellors and therapists and in this respect engage at a community and group level. Direct community based interventions do not form the scope of the study as discussed earlier in this report.

Aspects of narrative ways of working are: how the stories of our lives shape our lives, externalizing conversations, exploring the effects of problems, finding unique outcomes, historical explorations and the (community) creation of new stories, the naming of injustice, questioning of culture, acknowledging the political nature of the topics discussed in therapy and finding ways that therapy is mutually enriching through the technique of re-membering and inviting outsider witnesses to stories and ceremonies (Morgan 2000).

In this study narrative family therapy is used because of its relevance to community and context-rich practice, its emphasis on story-telling, de-

stigmatizing and the empowerment of people to find and live their preferred stories.

1.3.5 Co-researchers

In the study research 'objects' or 'population' are referred to as research 'participants' or 'co-reseachers'. This emphasises the participatory nature of the study and the importance of subjective integrity (Muller 2003).

1.3.6 Discourse

"*A historically, socially and institutionally specific structure of statements, terms, categories and beliefs that are embedded in institutions, social relationships and texts*" (Scott 1990 in Weingarten 1998:7).

In this study discourses are described as experienced and interpreted by the researcher and co-researchers, namely the people living with HIV/AIDS, church leaders and lay counsellors.

1.3.7 Discourse Analysis

"Discourse analysis can be defined as the act of showing how certain discourses are deployed to achieve particular effects in specific contexts" (Terre Blanche, Durrheim & Kelly 2007:328).

In this study discourse analysis is used to make it possible for co-researchers to speak their minds in their language and to ascertain discourses prevalent in the cultures they represent.

1.3.8 Post Modern Theology

The need to include information and literature on theology is important, because in this study issues of faith are important informants to the way the research participants give meaning to their actions and experiences.

Post modern theology has the following characteristics (Herholdt 1998) that are interwoven or feature in the stories related by co-researchers:

- People organize their lives with God as Creative Participant, and people are interconnected with God as Leader of the community.
- Truth is relative to a particular social context, intellectual climate, and cultural category.
- Openness for non-conceptual, intuitive and mystical ways of knowing; knowledge includes personal experience.
- Every generation has to discover meaning for themselves by means of metaphoric reference to Scripture; God is re-conceptualized in verbal terms, hence use of metaphors, for example, 'God the Father', 'God's transcendence'.
- Theology becomes an instrument to weave religious content into one's personal life and to engage in interdisciplinary dialogue.

In this study, several concepts of post modern theology are discussed in practical narrative theology and narrative and contextual family therapy.

1.3.9 **Practical Narrative Theology**

"*Practical narrative theology can be described as locally contextual, socially constructed, directed by tradition, exploring interdisciplinary meaning and pointing beyond the local community*" (Muller 2005:3).

In this study practical narrative theology provides the preferred theological under-building for the training of pastoral family counsellors, the target group of the study.

1.3.10 **Pastoral Counselling**

Pastoral counselling is a specialised type of pastoral care offered in response to individuals, couples or families who are experiencing and are able to articulate

the pain in their lives and willing to seek pastoral help in order to deal with it. A pastoral counsellor is a representative of an image of life and its meaning affirmed by his or her religious community. The pastoral counsellor offers a relationship in which that understanding of life and faith can be explored (Patton 1993).

In this study pastoral counsellors are perceived as communal, listening to people's stories and silences and representing resources and church in community.

1.3.11 Community Practice

People are constantly defining and engaging in enterprises of all kinds. Learning through interaction with each other and the world, the sustained pursuit of shared enterprise is community practice (Wenger 1998).

In this study, family therapy and family education are regarded and developed as community based practices.

1.4 AIMS, OBJECTIVES AND KEY QUESTIONS

The study aims to explore the following:

- The nature of the personal and relational problems facing a person living with HIV/AIDS and the nature of the problems facing families and communities affected by HIV/AIDS.
- The nature of services offered by pastoral counsellors to families in their AIDS-affected communities, and the effects of these services.
- The nature of further training needs of pastoral counsellors for the counselling practices in their churches.

- The nature of family therapeutic counselling training in the context of pastoral counselling as being taught at institutes nationally and internationally, and its relevance for the training of pastoral counsellors in Southern Africa

- The effectiveness of a training programme for pastoral counsellors in contextual and narrative family therapy skills for use with families with HIV/AIDS

These aims will be accomplished by

- Conducting a 'state of the art review' of personal and relational problems facing families living with HIV/AIDS and of family therapeutic counselling services available to them.

- Designing a training programme in contextual and narrative family therapeutic counselling for church leaders and lay counsellors.

- Developing such a programme with church leaders and lay counsellors.

Key questions to be answered in the research

- What is the nature of personal and relational problems facing a person living with HIV/AIDS, their families and their communities?

- What is the nature of services offered by pastoral counsellors to families with HIV/AIDS, and what are the effects thereof?

- What training model/programme can be designed in contextual and narrative family therapeutic counselling that will be useful for church leaders and lay counsellors?

1.5 <u>THEORETICAL UNDERPINNINGS OF THE STUDY</u>

This section discusses the overall approach to the study which is postmodernism, with justification. Thereafter, two complementary paradigms of post-foundationalism and social constructionism are discussed as providing the specific backdrops to the study.

1.5.1   Firstly, the context of this research study is a post modern world, although some philosophers talk about a past- post modern world, which they have identified as an integral world (Wilber 2006). The post modern world has moved away from the power and authority of science, and from expert objective knowledge that is founded in absolute truth. It believes that different people understand and experience the world from different perspectives. The language people use, the statements they make, the terminology and categories they use, and the discourses they represent reveal how they know and construct their society (Becvar & Becvar, 2000).

Post modernism believes in "multiplicity, plurality and indeterminacy … and in meaning that is particularized, relative and mutable" (Moules 2000:230). Postmodernism takes a stance against the belief in one single worldview, and is informed by different disciplines, such as philosophy, culture, social sciences and religion. Meaning attached to what people know about their world becomes particular, experienced within a certain group or community. It cannot be said to be true and provide meaning to all. Each community constructs their own ideas about life and therefore reality is described differently. A post modern approach to social science would therefore emphasize cultural sensitivity, acknowledge cultural differences and historical specificity and recognise that theories about the life world of people are embedded in discursive fields (Babbie & Mouton 2001). In this study, the multiple realities of several different sources are researched to arrive at meanings that are ascribed to different contexts and cultures.

Deconstructive postmodernism sets out to deconstruct discourses that claim universal truth and are presented with powerful and negative statements of belief, such as the assertion that HIV-positive people are black and sexually promiscuous. The aim of such a deconstruction is to explain, challenge, critique and transform the negative discourses of society. Thiselton, describing Gadamer's hermeneutics of radical metacritical reflection, mentions in this context three levels of understanding:

- Firstly the researcher will experience what the text is saying and immerses in the story.
- Secondly the researcher will look at the text and critique the discourse.
- Thirdly the researcher will give a metacritical evaluation of the given critique (Thiselton 1992).

In the study, the researcher would immerse in the stories of people living with HIV/AIDS, then describe and interpret the discourses in their stories, based on different pre-understandings of people living with HIV/AIDS, (who are referred to as co-researchers), as well as being informed by literature, and then critique this critique by describing and interpreting the interests of families living with HIV/AIDS and the interests of service providers, e.g. churches. These discourses are all considered and given respectful recognition in finding a joint perspective of constructive action.

In the study, the researcher will focus on interpretive descriptions of reality, understood and constructed within social relationships (Babbie & Mouton 2001). The researcher and co-researchers painstakingly emphasize the influence of family, culture and language on the creation of meaning and in arriving at best practice options (Moules 2000).

Research within the critical tradition would not only give an interpretive description of reality, but also describe the structural conflicts in the social order. The study acknowledges such social deficits as a backdrop to the findings,

provides a voice to marginalized and underprivileged groupings in society, describes some of their discourses, determining which language and meanings dominate and how their reality is constructed (Gergen 1994 in Becvar & Becvar 2000). The study focuses on moral and social responsibility in deconstructing oppressive discourses that influence counselling practices.

The researcher will now proceed to discuss the specific underpinnings of social constructionism and post foundationalism that satisfy the precepts of post modernism. Both social constructionism and post foundationalism are explained at this early onset in order to provide a theoretical frame for underpinning or approaching the present study.

The researcher seeks to integrate the paradigm of social constructionism and the paradigm of post foundationalism and explains this hereunder.

1.5.2   Social Constructionism

Social constructionism is described as "synonym to post structuralism, deconstructionism and the new hermeneutics" (Freedman & Combs 1996:14).

Social constructionism aims to construct reality in a social context.

"The moment of praxis, the life world of people living with HIV is always local, embodied and situated" (Muller 2005:1). The individual is viewed as a participant in various relationships, and narrated realities. Therefore social constructionism is opposed to relativism, individualism and intra-psychic ideas of constructing reality. In this study, contextual and community issues are accorded high regard as counsellors are required to offer a meaningful therapeutic service that deeply considers these realities.

Language is of central importance, as the means by which people come to know and construct their world. Language doesn't reflect reality, but creates it (Moules

2000). Language is also perceived as a socially constructed system, which through dominant and privileged discourses, creates power imbalances.

Social constructionism is therefore "concerned with explicating the processes by which people come to describe, explain or otherwise account for the world in which they live" (Gergen1985: 266 in Becvar & Becvar 2000). These are value-driven processes, by which people construct their preferred realities. The researcher describes how these values are interpreted in the life world (social construct) of families living with HIV/AIDS.

The hermeneutic approach of interpretation of these discourses, the interpretation of their meaning, demands a mutual and homogenous understanding of reality (Kvale 1996). In considering all realities, final positions are thus multi-partial, even though they are expressed as a homogenous understanding, and in this study as a final training product, that derives from these realities.

1.5.3   Post-foundationalism

Post-foundationalism starts along similar lines as social constructionism. People's life stories are seen as a description of their reality, informed by societal beliefs. Identity and therefore rationality - who people are and what people believe - is socially constructed (Muller 2003). "These beliefs occur as a groundless web of interrelated beliefs, which mutually reinforce each other, and there is no single foundational truth on which this system of beliefs is based" (Van Huyssteen 1997:3-4). This does not imply that just anything can be believed. Only those beliefs are justified which are held by a rational person. A rational person is capable of making responsible judgments, using their cognitive, evaluative, and pragmatic contexts as resources of rationality. This requires that the person can speak with authority (experience and expertise) as well as that the person must resign his beliefs to the community of those who share the relevant experience and knowledge (Van Huyssteen 1998). Herein, the power of

individual experience is accorded respect, a consideration taken seriously by the researcher in securing individual life stories and experiences before arriving at a homogenous product (the training programme). The reciprocal relationships across individual and society are thus deeply respected.

These shared resources of human rationality enable dialogue between different contexts, cultures and disciplines (Van Huyssteen 1997). In the study, multiple positions are invited, both representing individuals and the community, culminating in a training programme that connects with or has meaning for several contexts and targets simultaneously.

Post-foundationalism deals with the balance and dialogue between tradition (beliefs, culture) and context (reality, experience). The philosopher Wittgenstein (1963) refers to this dialogue where he says that meaning is determined by use. The meaning of a word is determined by the action with which it is associated, which means that action determines meaning. Language acquires meaning by means of social practice (Wittgenstein in Beckvar & Beckvar 2000). Such rich descriptions based on action and experiences of community members are sought in the conduct of this study.

Post-foundationalism positions itself as a viable third option between objectivism and relativism, foundationalism and postmodernism (Van Huyssteen 1997). Therefore, post-foundationalism considers rationality to be socially constructed, as people are living together in concrete situations and contexts, but it also recognizes the construction of rationality and identity based on a person's 'own experience', which is interpreted experience. Alternative interpretations would come through the study of sciences and be perceived as complementary understanding of reality, emphasizing tradition, culture and cultural discourses (Van Huyssteen 1998).

Social constructionism seeks to find meaning and truth in the stories of the oppressed and marginalized. Emphasizing historical background and culture-

bound interpretations, it attempts to find structural causes for inequality in power relationships. Within post-foundationalism, the emphasis is more on 'webs of beliefs'. Such webs of beliefs aim for a systemic interpretation of action and look for a holistic picture, recognizing differing spiritual, ethical and moral perspectives. However, post-foundationalism does not stop there, but maintains that the varying webs of beliefs that result, these different constructs of reality, then should interact and negotiate to come to a common understanding. These concepts are applied to the study by accessing both individual stories of persons but also when these stories are embedded in community-rich actions, descriptions and experiences that are also analysed before reaching the final product of the training programme.

1.5.4   Post-foundationalist Practical Theology

Deconstructive postmodernists have argued that the meaning of God and beliefs only exists within constructed distinctions in language and therefore religion and spirituality do not exist (Moules 2000). The postmodern philosopher Lyotard criticises the meta-narratives or grand belief systems as they contain a universal acceptance of reality (Eskens 2003). Bediako, however, describes the meta-narrative of Scripture as constructed through the activity of God in building up a community of His people throughout history, which includes their particular language (mother tongue), traditions, history and culture. A shared family likeness was thus created through communal shared knowledge from ancient and modern times, whereby other Christian stories are illuminating our personal stories (Bediako 2001).

Muller merged concepts of post-foundationalist theology and narrative theology into a research process for practical theology. The researcher will use his seven movements in this study, as they were considered relevant for both the personal life experience and meaning-giving of individuals, their contextual interaction and the role and experience of God's working and meaning-giving in our world. Muller qualified the African approach to practical theology and science in general

as "holistic, circular and narrative" (Muller 2003:294). Three distinct forms of narratives are to be found in narrative theology, namely the canonical stories, which focus on Biblical materials, life stories, which focus on human experience and community stories, which focus on the classical Christian tradition (Fackre 1996). Narrative theology emphasizes the centrality of communal experience to the life of the church. God tells His story through the Church. Individual life achieves meaning through participation in this narrative. Jacobs comments here that the narrative integrity and wholeness of a given single life still needs to be acknowledged (Jacobs 2003). MacIntyre agrees that the notion of personal identity is related to the notions of narrative, intelligibility and accountability. He argues that the unity of an individual is the unity of a narrative embodied in a single life (MacIntyre 2002). In this notion, the researcher sees how post-foundationalism and social-constructivism are operational in that individual action and experience is acknowledged, interpreted and informed within the context of the local community.

Narrative post-foundational theology, being both contextual and engaged in interdisciplinary conversation, acknowledges the individual's narratives, and their preferred truths. Here again the researcher employs an interdisciplinary stance by linking pastoral counselling to family therapy for community counsellors, using co-researchers' preferred truths and narratives in the creation of the training model.

1.5.5 The social constructionist/post foundational paradigm

In social constructionism, the emphasis is on subjectivity, the effect of culture, and circulation of meanings through language. "the subject originates nothing" Post-foundationalism also acknowledges contextuality and interpreted experience, but recognises 'human uniqueness' and vulnerability embedded in bodily existence. The focus is on interdisciplinary dialogue and to critically relate to the historical-cultural network of ideas in which traditions and worldviews are embedded.

Both narrative- and contextual pastoral family therapy are well placed within the social constructionist/post-foundational paradigm, which informs the therapeutic stance and choices and provides a useful theoretical frame against which data for the training model are collected, collated and homogenously presented in this study.

The researcher believes that the post-foundationalist approach to interdisciplinary conversations is helpful to move beyond the contextual and cultural boundaries of the church leaders and lay counsellors and critically explore the beliefs and meanings they construct of their worlds. Narrative therapy supports the evolving of new interpretive positions as a result of dialogue and communicative action resulting in changing realities (Parry & Doan 1994).

The following section will focus on the research design and the methodology which will be explained in greater detail in Chapter Two.

1.6   RESEARCH DESIGN AND METHODOLOGY

- The researcher will use the Intervention Research Model as developed by Rothman and Thomas (1994) as the overall research design. The structure in this model is utilized to offer a state of the art review of all contributing possibilities that will enrich the development of the training programme in contextual and narrative family therapeutic counselling for church leaders and lay counsellors (De Vos 2001). Details of how the model was used are found in chapter five. A summary of the specific steps involved in this model are discussed later in this study report.
- Within the overarching Intervention Research Model, the researcher will make use of the five-step ABDCE model, as developed by Alice Adams (in Muller 2003). This model is a social construct and narrative based model for story writing and analysis and is discussed in further detail later in the

chapter. The model is utilized for the description and interpretation of the life world of families living with HIV/AIDS.

- In addition to the Intervention Research Model, the researcher will make use of the seven-step model, as developed by Muller (2004). This includes a post-foundational and narrative based research approach and is considered essential in developing the course content and learning materials of the training programme in contextual and narrative family therapeutic counselling with church leaders and lay counsellors.

1.6.1 The Intervention Research Model

The Intervention Research Model as developed by Rothman and Thomas (1994), is a combined qualitative-quantitative method, and seems the most appropriate research design for the development of the training programme in contextual and narrative family therapeutic counselling for church leaders and lay counsellors

Intervention Research is an integration of Thomas's Developmental Research and Utilisation model DR&U (1981), his later developed Design and Development model (1984) and Rothman's Social Research and Development Social D&D (1980), (De Vos 2001:384). The design and development perspective seem relevant where the researcher wants to apply existing and newly discovered knowledge and develop and design "a product", a training tool for community pastoral counsellors. Further, the model allows for a mixed methodologies approach that in this study means gleaning context and community rich perspectives of several target groups.

 Intervention research focuses on questions of intervention, which are aimed at understanding of and intervening in the reality of the HIV/AIDS pandemic experienced in community life. This reality is complex and has to consider

several layers of meaning and context that may be accommodated with the adoption of this research paradigm.

The six major phases of Intervention Research are:

1. **Problem analysis and project planning**

   - Identifying and involving co-researchers.
   - Forming collaborative relationships with key informants and gaining entry and cooperation from settings.
   - Identifying concerns of the different target populations.
   - Designing a protocol for the analysis of identified problems and concerns.
   - Analyzing identified concerns, themes and discourses.
   - Providing an overview of existing interventions: "state of the art review".
   - Providing information to assess whether relevant interventions already exist and further development is merited.

2. **Information gathering and synthesis**

   - Using existing information sources.
   - Studying natural examples, articles, interviews, etc.
   - Identifying functional elements of successful models.

3. **Design**

   - Designing an observational system:
     - Providing an observational protocol.
     - Preparing instructions to guide the observation and the recording of the skill components of the intervention.
   - Specifying procedural elements of the intervention.

4. **Early development and pilot testing**

- Developing a prototype programme:

  - Establishing and selecting of a mode of delivery.
  - Specification of selection criteria and procedures for potential users.
  - Selection and specification of intervention procedures.
  - Trial use of the prototype in the pilot test.
  - The use of feedback from trainees to help redefine and simplify the prototype.

5. **Evaluation and advanced development**

- Selecting an experimental design.

  - The experimental design demonstrates causal relationships between the interventions and the behaviours and related conditions targeted for change.

- Collecting and analyzing data.

  - During the pilot study, data are continuously collected and analyzed by the researcher and participants (co-researchers).

- Replicating the intervention under field conditions.
- Redefining the intervention.

6. **Dissemination**

- Preparing the product for dissemination.
- Identifying potential markets for the intervention.
- Creating a demand for the intervention.

- Encouraging appropriate adaptation.
- Providing technical support for adopters.

As can be seen, each phase is comprised of a number of steps.

In Chapter Two, when discussing research methods used in this study, the researcher will show an application of the Intervention Research model to the present study.

The next section concerns the ABDCE Research Model, which is used in analyzing the stories in the literature chapter and narratives and research participants. It is introduced in this section to provide further information on the general research frame and approach used in the study. The model provides a basis for describing and interpreting the life worlds of families living with HIV/AIDS and the life world of the churches. It offers an appropriate and organised way of reading and analysing text and arriving at directions for change and action.

1.6.2 The ABDCE Research Model

The ABDCE Research Model was developed from Alice Adam's formula for fiction writing, as referred to by Anne Lamott and applied by Muller (2003) as a social construct and narrative based research model.

The model guides a researcher to read a story in a specific way. The de-constructivist agenda is to describe, unpack and explore alternatives of a story; focussing on, in this order, Action, Background, Development, Climax and Ending.

Action

The emphasis is on action, the action field, not only to focus on the problem areas in the participant's life, but on all their action, routines and beliefs. The focus is on the 'here and now'. The researcher needs to consider the action and

action field and decide on what action to research, and select on how to interact with the action. The researcher shows transparency in this process.

Background

Persons and/or the discourses which played a role in the development of this particular action field are explored.

The researcher explores the background to relational partnerships with significant others, which will also include relationships to community, institutions and facilities. The focus is on contributions that have been made or have been lacking related to the action field and on others who are affected by this contribution or lack of contribution.

Development

The interaction between the action and background stories will create a broad spectrum and collective understanding and provide meaning and ideas as well as a description of the problems and themes that need more exploring through relevant literature study.

Climax

The process of "Action-Background-Development" will hopefully culminate in finding the unique outcomes and construction of new narratives.

A social constructionist and narrative approach to research sets the scene in motion and waits for the climax to develop.

Ending

The research process is a description, a reflection, a critique, a new writing. Narrative research ends with an open ending. The ending relates to the provision of new perspectives.

1.6.3 The Post-foundationalist Practical Theology Model

This study was aimed at church leaders and lay counsellor, therefore research methodology embedded in the narrative/post-foundational paradigm was necessary in challenging,   analysing and informing the life world of this target group and was deemed most suitable.

The methodology in this seven-step model, as developed by Muller (2004), derives not exclusively from social science but also from practical theology. The methodology was developed using the language as spoken in the "community of knowledge" of church leaders. Traditional and cultural discourses which developed within the church community are described and interpreted within the context of families and churches living with HIV/AIDS. Using this methodology for the development of the course content and learning materials of the training programme in contextual and narrative family therapeutic counselling makes the training more relevant and applicable for theological educators, students and church leaders.

The Post-foundationalist Practical Theology Model given by Muller (2004:300) is as follows:

The context and interpreted experience

1. A specific context is described.
2. In-context experiences are listened to and described.
3. Interpretations of experiences are made, described and developed in collaboration with "co-researchers".

Traditions of interpretation

4. A description of experiences as it is continually informed by traditions of interpretation.

God's Presence

5. A reflection on God's presence, as it is understood and experienced in a specific situation.

Thickened through interdisciplinary investigation

6. A description of experience, thickened through interdisciplinary investigation.

Point beyond the local community

7. The development of alternative interpretations that point beyond the local community.

1.7   Outline of the Remaining Chapters

In Chapter Two, the researcher will discuss further, and more specifically, the research methodology as used in this study.

Chapter Three and Four comprises a literature study of the topics outlined for research, to the end of answering the key questions in Section 1.4 of this Chapter.

In Chapter Five, data collected as part of the first phase of the Intervention Research is analysed.

Chapter Three, Four and Five are used to determine the training needs of church leaders and lay counsellor regarding their counselling intervention with families with HIV/AIDS and the content of the training programme.

Are families living with HIV/AIDS in need of counselling services and is the development of a training programme in narrative and contextual family therapeutic counselling a necessary method of helping and strengthening such families?

Chapter Five outlines the designing, piloting and development of the intervention in the form of a training programme in contextual and narrative family therapeutic counselling for church leaders and lay counsellors

Conclusions are presented in Chapter Six, as well as recommendations for further research and practice.

CHAPTER TWO

RESEARCH METHODOLOGY

2.1 <u>INTRODUCTION</u>

This study is concerned with the reality that families living with HIV/AIDS are faced with a magnitude of problems and do not receive adequate counselling support. As discussed in the first chapter, families in the community often receive support from voluntary faith-based counsellors. However, given the need to comprehensively address the problems and needs of families living with HIV/AIDS, there exists a shortage of trained pastoral family therapeutic counsellors in the churches in Southern Africa. The researcher undertakes to analyse this situation and to recommend how best pastoral counsellors can serve these families.

This chapter discusses the research approach used in the study, alluded to in the first chapter. The term co-researcher is used for participants in the research process, consistent with Muller's description of narrative researchers, whose research objectives should be of value to their research participants (Muller 2003).

The methodology of the Intervention Research Model (IRM) was viewed as catering perfectly for an overall framework to structure the analysis of key components that need consideration before finalising the best practice programme as follows :

- the life world of families living with HIV/AIDS
- the life world of the churches
- the problems and themes needing intervention as viewed by families living with HIV/AIDS and by the churches
- the design, implementation and development of a suitable intervention.

During the information gathering (phase 1 of the IRM) and synthesis (phase 2 of the IRM) use was made of several methods of data collection, such as observation, questionnaire interview, survey, unstructured and semi-structured interviews, focus groups, study groups, participant checks, literature search, and web search. The need for using multiple sources is consistent with reference to adoption of a post modernist theoretical stance which was cited in chapter One as believing in "multiplicity, plurality and indeterminacy … and in meaning that is particularized, relative and mutable" (Moules 2000:230).

During the analysis and literature review phases (phases 1 and 2) of the IRM, use was made of qualitative and quantitative analysis methods, consistent with the data collection method. In addition, the following two research procedures were employed with respect to the description of the life world of families living with HIV/AIDS, as described in literature and by the co-researchers and the concerns, themes and discourses as derived from such.

- Anne Lammot's ABDCE formula (for the analysis of narratives).
- Muller's Post Foundationalist Practical Theology 7 movements (for the development of the training content and materials).

Both procedures were also used during the operational steps of the intervention research in designing a protocol for the analysis of identified concerns, themes and discourses. The procedures were consistent with the steps of the intervention research.

These procedures formed a framework for a multidisciplinary and multi faceted approach to the design of training materials for family counselling training of church leaders and lay counsellors.

Narratives organise meaning, they construct particular realities, truths about the life world of families living with HIV/AIDS and the life world of the Churches. The researcher made use of the following analytic techniques to gain a better understanding of and be able to reflect on these constructs:

- Deconstruction and re-construction of social meaning
- Triangulation
- Peer review or debriefing
- Descriptive statistics

During the design (phase 3 & 4 of the IRM) and evaluation (phase 5) use is made of the following qualitative and quantitative procedures:

- Member checks (participant validation)
- Rich, thick description of texts
- Clarifying researcher- bias
- Participatory interaction, using subjective integrity

Operationalisation of terms in the design of observational systems used the following:

- Course design
- Assessment
- Evaluation of counselling practice skills

The above mentioned research methods and procedures, are a key example of the value of triangulation. Materials are collected in different ways and from different sources, and the variety of procedures enables the researcher to develop a richer description, and understanding of language and discursive fields, both through the variety of data gathering sources as well as the variety of steps in the process of analysis, discussion and reflection (Kelly, 2007). This again is consistent with the theoretical approaches of Lammot's ABDCE formula and Muller's 7 movements where the need is for in-context description of experiences, thickened by interdisciplinary investigation.

2.2 THE INTERVENTION RESEARCH MODEL

A tabular summary of the IRM model is hereunder presented to clarify the multiple data sources, sample details and steps used in the conduct of the study. For this study, the researcher completed phases 1 through to 5 which end at early development and pilot testing of the "product". The study was completed in 2008, with attention now being afforded to the last phase of dissemination of the best practice training programme. The table hereunder explains the phases, operational steps taken in fulfilling requirements for meeting the phase outcomes and information sources or sample details that were used for in respect of each phase.

Table 2.1. The Intervention Research Model. Adapted from De Vos (2001: 385)

PHASE	OPERATIONAL STEPS	INFORMATION/SOURCES/ SAMPLES/TARGET GROUPS
1. PROBLEM IDENTIFICATION, ANALYSIS AND PROJECT PLANNING	1. Identifying and involving people living with HIV/AIDS, church leaders, and lay- counsellors, as co-researchers. 2. Forming collaborative relationships with key informants and gaining entry and cooperation from settings. 3. Identifying concerns of the different target populations. 4. Designing a protocol for the analysis of identified problems and concerns. 5. Analyzing identified concerns, themes and	In-depth interviews with 5 members of a support group of people living with HIV/AIDS. Survey with 100 church leaders and lay-counsellors who have been trained by Siyahlanganisa Centre. Questionnaire (including construction of community profiles) with 50 church leaders and lay-counsellors based at churches in 5 different types of geographical areas in the greater Durban area. Information about community-based social service providers as identified by the church leaders and lay-counsellors through questionnaire's and their community profiles.

	discourses.	
	6. Providing an overview of existing interventions: "state of the art review".	10 focus group interviews with church based counsellors in 5 different types of geographical areas in the greater Durban area.
	7. Assess whether relevant interventions that already exist are sufficient and whether further development is merited.	3 focus group interviews with church leaders in 3 different types of geographical areas in the greater Durban area
		Questionnaire interview with 36 church leaders, related to the outcome of their Siyahlanganisa training.

PHASES	OPERATIONAL STEPS	INFORMATION/SOURCES/ SAMPLES/TARGET GROUPS
2. INFORMATION GATHERING AND SYNTHESIS	1. Using existing information sources. 2. Studying natural examples, articles, interviews, etc. 3. Identifying functional elements of successful models.	Literature review of: • The life world of families living with HIV/AIDS. • The role and history of the churches and their involvement with families living with HIV/AIDS. • Theory and practice of contextual and narrative family therapy related to families living with HIV/AIDS. • Family therapeutic training models for pastoral counsellors.

PHASES	OPERATIONAL STEPS	INFORMATION/SOURCES/ SAMPLE/TARGET GROUPS
3. DESIGN	1. Designing an observational system: Provide an observational protocol to assess: • knowledge base • skills • quality of counselling • personal development • report writing Prepare instructions to guide the observation and the recording of the skill components of the intervention, e.g. genogram, role-playing. 2. Specifying procedural elements of the intervention • ascertain problems and themes relevant for training • identify/work with gatekeepers • planning • contextualising course material • marketing • implementing • evaluation • supervision	The developed data are verified with people living with HIV/AIDS, church leaders and lay-counsellors, and theological educators. The data are used to specify and define what needs to be changed: • Problems and discourses of families who are living with HIV/AIDS. • What counselling support families living with HIV/AIDS are needing in order to deal with their problems, e.g. extended grief. • The provision of trained pastoral family counsellors. Examples of problems facing families living with HIV/AIDS are provided as case studies and translated in operational terms of contextual and narrative family therapy).

PHASES	OPERATIONAL STEPS	INFORMATION/SOURCES/ SAMPLES/TARGET GROUPS
4. EARLY DEVELOPMENT AND PILOT TESTING	1. Developing a prototype programme: • Establishing and selection of a mode of delivery (e.g. training programme). • Deciding on selection criteria and procedures for potential trainees. • Selection and specification of intervention procedures (including contextual and narrative family therapeutic counselling). • Trial use of the prototype in the pilot test. • The use of feedback from trainees to help redefine and simplify the prototype of the training programme.	A practice based manual and reader is developed that provides information about psycho-social problems, skills development, counselling approaches and exercises. Criteria and course information was specified with Principal of Bible College, who then recruited his students and hosted the course. A course content participant guide is developed to familiarize the course participants with the procedures. Pilot test implemented at Bible College, with group of 10 students (co-researchers). Second pilot study with group of 30 church leaders and lay counsellors at local church Third pilot study with group of 25 community workers at hospice Ongoing assessment of adequacy of training programme by researcher and participants (co-researchers).

PHASES	OPERATIONAL STEPS	INFORMATION/SOURCES/ SAMPLES/TARGET GROUPS
5. EVALUATION AND ADVANCED DEVELOPMENT	1.Selecting an experimental design The experimental design demonstrates causal relationships between the interventions and the behaviours and related conditions targeted for change. 2. Collecting and analyzing data During the pilot study, data are continuously collected and analyzed by the researcher and participants (co-researchers). 3. Replicating the intervention under field conditions 4. Redefining the Intervention	Family-of-origin work demonstrates understanding and application of information gained by the participants at the training course. Designing and performing role plays, demonstrates skills development in counselling skills, and insight in how families are helped in dealing with their problems. Evaluation of the intervention takes place through e.g. pre and post training questionnaires and student's peer assessments. Facilitating under field conditions will happen when intervention is repeated with other groups of participants in the same or another setting. Instructions and manuals need to be developed, tested and revised. A supervisory system needs to be developed to assess trainee competence, personal development, and external accountability

PHASES	OPERATIONAL STEPS	INFORMATION/SOURCES/ SAMPLE/TAGRGET GROUPS
6. DISSEMINATION	1. Preparing the product for dissemination. 2. Identifying potential markets for the intervention. 3. Creating a demand for the intervention. 4. Encouraging appropriate adaptation. 5. Providing technical support for adopters.	Deciding on a name, the right price and options for funding, deciding on unit standards and having the programme SAQA accredited. Setting standards and guidelines for the use of the product. Advertising the training programme: by word of mouth, the media, and presentations for fraternals and churches. Bible Colleges and seminaries in Southern Africa can be encouraged to adapt and implement the programme. Other training institutions involved with family therapeutic counselling can be encouraged to adapt and implement the intervention. Developing a structure to coordinate, facilitate and monitor training programmes in contextual and narrative family therapeutic skills training.

2.3 The ABDCE RESEARCH MODEL

Lamott (in Muller, 2003)

As discussed, this model is used within the overarching intervention research as it provided for an orderly and systematic way of describing the action field of families living with HIV/AIDS and the researcher's interaction with the text and the research participants. The post-foundational and social constructionist theory supports involvement and interaction with families living with HIV/AIDS, description of their action and action field from a variety of perspectives in order to gain understanding of their and their families knowledge, perceptions and attitudes as well as those of their communities and surrounding churches.

The ABDCE research model provides a more specific framework to process the analysis of themes and problems that arise from the analysis of the following:

- the life world of families living with HIV/AIDS
- the life world of the churches

The steps used in the Lamott model are discussed hereunder as they applied to the study in respect of narratives of families living with HIV/AIDS.

2.3.1   Action

Lamott discusses action in a deconstructivist manner, action needs to be described in order to be unpacked and alternatives to be explored (Muller 2003). The researcher satisfied this aspect by participating in action and action fields in the following ways :

a) Face-to-face, non structured, individual interviews with support group members who are living with HIV/AIDS.

Sampling method: purposive participative sampling.

Purposive sampling satisfied the researcher's purposes and is generally used to work with co-researchers who are available, willing to participate and representing the selected population, here people living with HIV/AIDS. The

researcher chose this particular group because she participated in this support group since it started in 1998 and appreciated that it would fulfil the need for in-depth information about the life world of people living with HIV/AIDS. The group represents a variety of 'life worlds' as the members represent different traditional and cultural discourses. The researcher interviewed 5 support group members. The researcher chose the method of non-structured interviewing, because she wanted to enter the life world of the person or the couple from a perspective of 'not knowing' (Kotze & Kotze 2001) as this stance was necessary for their voices and stories to be heard (discussed in chapter one).

The second method used in participating in action/action fields as discussed by Lamott was as follows:

b) The semi structured group interview

Sample: the sample was the same support group members living with HIV/AIDS and they readily fulfilled the need for this aspect of the study.

The semi-structured group interview took the form of a body mapping workshop and the materials were made available to the researcher as additional and original information about the participants. The workshop assisted the group members to interact in a creative way to uncover how living with HIV/AIDS affects different areas in their life. The 'mapping our lives' intervention was aimed at assisting the group to find empowering themes in their own lives. Drawn on life-sized pieces of paper, they filled in their 'traced body' with images, words, patterns, designs and scars (Almeleh 2004). The information from the body maps added to the stories of the life world of the support group members.

The third data source used was as follows:

c) Survey with 100 church leaders and lay counsellors, who have been trained by Siyahlanganisa Centre in 2005 and 2006.

Sampling method: non-probability convenience sampling people on the training courses.

The research participants were church leaders and lay counsellors trained by Siyahhlanganisa Centre. The questionnaires were distributed to the available trainees on a particular day, so the date for questionnaire distribution was selected out of convenience as was the participants that were available at the time.

This survey provided an overview of the different counselling and supportive activities that took place in participants' churches. Descriptive statistics were used to project the findings. For this study the survey created an action field of the life world of these churches and provided an indication of the themes and problems that these churches and their communities experience.

d) Questionnaires with 50 church leaders and lay counsellors based at churches in 5 different types of geographical areas in the greater Durban area. The participants were all trained by Siyahlanganisa Centre in 2006 and 2007.

> Sampling method: stratified non-probability convenience sampling, with random sampling within the population of people on the training courses.

The questionnaire's were randomly distributed to available trainee's on the Siyahlanganisa training courses. Stratified sampling was used in the selection and representation of specific areas considered significant for the purposes of the study.

Participants represented urban, rural, semi-rural, townships and areas of informal settlement.

This questionnaire specifically asked about the action field of family counselling practice in the participants' churches, their referral options and the need for further training of church counsellors.

During their training, the participants produced community profiles, which have been utilized in this study, in order to provide a more comprehensive picture of the community life and service provision. The richness of these profiles contributes to relevancy of the "product" by ensuring that contextual issues are considered.

e) Ten focus group discussions with participants of the Siyahlanganisa counselling training courses in 2006 and 2007.

Sampling methods: non-probability sampling, purposive participative and critical case sampling and snow ball sampling

Participants of the Siyahlanganisa training courses who resided in the same areas were invited to participate because the researcher believed they would provide valuable, exceptional data (critical case sampling). These respondents were then asked to identify other possible respondents (snow ball sampling) who could also provide rich data. Critical case sampling is used when participants provide particular and exceptional information-rich and enlightening data, which informed about particular actions and action fields of the (church) communities, which might involve finding interpretations for exceptional cases. This is discussed by Kelly (2007) and the researcher satisfies the need to gain understanding of the life world of HIV positive families and their surrounding Churches.

The focus groups were held in the communities where the participants lived and participated in their churches. Participants were invited, and in turn networked with invited others that were trained by Siyahlanganisa Centre.

The focus groups were aimed at assessing the counselling practices in the respective communities of the participants. They also served to identify dominant discourses at play in these communities.

The sixth method used in participating in action/action fields as discussed by Lamott was as follows:

f) Three focus group discussions, with church leaders in different communities in Kwa-Zulu Natal, focussing on their role as leaders related to the action field of their Churches in the communities and their interactions with the life world of people living with HIV/AIDS.

Sampling methods: purposive participative and critical case sampling.

The Church leaders were part of fraternals, which are small groups of church leaders in a particular area who have regular meetings for fellowship, collaborative planning and community action.

The seventh data source used was as follows:

g) Questionnaire interviews with 36 church leaders, during their training by Siyahlanganisa centre in 2007, related to the envisaged impact of their training on the church communities.

Sampling method: non-probability convenience sampling, within the population of people on the training courses.

The questionnaire's were distributed to available church leaders, who were trainees on the Siyahlanganisa training courses.

In summary, the action and action field of people living with HIV, and their 'significant others' is described in the stories of the people involved and their thinking, experience, understanding, beliefs, attitudes, perceptions, knowledge

and behaviour. The data is derived both from the face-to-face interviews and the literature research.

The action and action field of the church community is described, making use of data from the Siyahlanganisa HIV/AIDS training programme. Through purposeful sampling, the description and interpretation of the action field of the course participants (co-researchers) will create another story of understanding.

The focus was on a geographical or denominational representation. Participants reflect on the life world of townships, suburbs, rural areas and the inner city. The researcher made use of snowball sampling by referring to the churches that the participants represent and church projects that they have identified as effective in helping families with HIV. The participants are perceived as co-researchers where they have been engaged in focus groups, discussion groups and a mapping exercise of their church communities during and after the training course. The data is also derived from literature research and web searches.

2.3.2 Background

The second step of Lamott's model interprets the action that is being researched in the context of historical perspectives, systematic concepts and cultural and religious meanings, as derived from the thick description of the action and action fields in step One. The background is now mainly presented through literature review of the life world of HIV positive families and the life world of the churches.

The study described the background to the life world of people living with HIV/AIDS, for example, the socio-political, religious and cultural background to their life story as well as the background to the life world of the church communities.

The researcher made use of 'practical wisdom' as mentioned by Browning (1991). The descriptive, historical and systematic interpretation of the action is described as three movements. The researcher used the literature research,

face-to-face interviews and focus groups with church leaders and lay-counsellors for this purpose, as well as the dialogue that took place about the presented literature and participants' life actions, meanings and pre-understandings, during the pilot study.

2.3.3 <u>Development</u>

This is the third step of Lammott's model.

The interaction is described according to various scientific descriptions. The researcher made use of interdisciplinary triangulation, whereby several interdisciplinary perspectives were compared which informed the findings of the first two steps in Lammott's model. A reciprocal dialogue took place between action and background. Throughout the analysis this became a spiralling process, as a richer description developed about people and discourses that played a role in the development of the action field of the life world of families living with HIV/AIDS and the role of the churches in the communities. The researcher made use of data triangulation, as she based her findings on a variety of data sources (Kelly, 2007). The research participants became the authors of the data described, hence the appropriateness of viewing them as co-researchers and being accorded respectful recognition. The aim was to create a common understanding in order to discern relevant themes and provide means of intervention.

The researcher's self-reflection on the interaction between action/background and development was shared with support group members, with Siyahlanganisa team members, and the research supervisor. Their reflexive feedback formed part and parcel of the construction of understanding and meaning of the intervention. It also served a validating function so that interpretations were checked against the experiences and understandings of the co-researchers.

The research is about people in action. For the researcher this is a process of reflection and facilitation; to listen to the participants with real compassion and to see things from their perspective. If research is about emancipation and transformation, the researcher needs to be prepared to wrestle with the participants through the development of a new story and to wait for new and more wholesome stories to develop. In a group and community context the importance is mentioned of common understanding of those involved. Muller refers to a "process of co-evolutionary communication" in order to co-create alternative narratives to the stories that have developed from the reciprocal dialogue between action and background (Muller 2003).

2.3.4 Climax

The understanding of the life world of HIV positive people and their surrounding churches that has thus far developed and resulted in a shared new understanding, based on narratives of action, reflection, and interaction with scientific disciplines, will now unfold in a climax, a culmination of new understanding and narratives of relationships between HIV positive people and their surrounding Churches. "All research participants and methods will co-create a denouement, which will culminate in new narratives" of the life world of families living with HIV (Muller 2003: 15).

2.3.5 Ending

The new understanding and narratives of the life world of HIV-positive people, the life world of the Churches and the new understanding and narratives of the relationship between them, will need a broad ownership and be tested in the practical situation. The aim of this stage is to create a common understanding in order to discern relevant themes and provide means of intervention. In order to do that, the themes need to be researched and developed in training materials. These materials need to be tested and further developed in the pilot studies. The new narratives need to be lived, strengthened and spoken about. These

materials need to be tested whilst applied to the practical counselling situation. In doing this, the researcher will again have to consider all possible research methods, and "involve the relevant individuals, families and communities in order to ensure a broad base of ownership" of the emerging knowledge and strategies (Muller 2003:15)

2.4 **The Post-foundationalist Practical Theology Model** (Muller 2005).

In addition to Lammott's ABDCE research model, which offers rich, various and approved data to the study, the Post-foundationalist Practical Theology model provides a more specific framework to process the emerged knowledge and strategies as arrived at using the ABDCE model. The Post-foundationalist Practical Theology Model is used for:

- The design, implementation and development of the training programme in pastoral family therapeutic counselling.

2.4.1 **The context and interpreted experience**

In this step, the researcher focused on the life world of the participants (co-researchers) in the pilot studies, as their personal and family life experiences and their work as assistant church leaders in various communities added valuable information to the design of the training programme. The students gained skills in contextualizing and interpreting their own life experiences, and through that process arrived at shared understandings. The following activities are described in this step:

1. *A specific context is described*. Description of the life world and discourses of families living with HIV in the (church) community in Southern Africa, their level of involvement in the churches, and the church's discourses

and involvement in the life world of these families. In this study this description and interpretation was developed within the ABDCE Model as outlined above. The participants in the pilot studies described their particular context of action and were guided by contextual and narrative therapeutic understandings.

2. *In-context experiences are listened to and described.* In this study the in-context experiences of participants (co-researchers) of the pilot studies are listened to and described. The participants in the pilot studies made use of contextual and narrative therapeutic language to describe their experiences.

3. *Interpretation of experiences are made, described and developed in collaboration with "co-researchers".* In this study, the participants in the pilot studies made use of contextual and narrative therapeutic concepts to interpret their in-context experiences.

Traditions of interpretation

This aspect encouraged the participants (co-researchers) to acknowledge voices, discourses and traditions in their families of origin and in society that informed and guided them in the interpretations of their life experiences. The step (activity) related to this is:

4. *A description of experiences as it is continually informed by traditions of interpretation.* Identification of specific discourses/traditions in families and (church) communities and within the churches which inform people's perceptions and behaviour. The researcher and participants (co-researchers) listened to the literature, the culture and the informative theological traditions of a certain context. The discourses and narratives

as developed within the ABDCE Model were also utilized as training materials for this exercise.

God's presence

This step related to the direct experience of God's Presence as the Other Person in the life world of the participants (co-researchers) and their capacity to acknowledge such Presence in the life world of families living with HIV/AIDS and their (church) communities. The students learned to respect the uniqueness of other people's experience and evolving story with God (Griffith in Walsh 2003).

5. *A reflection on God's presence, as it is understood and experienced in a specific situation.* A reflection on the religious and spiritual aspects and affects, of families living with HIV/AIDS. In this study the researcher and participants listened to and reflected on their religious and spiritual understanding and experiences of God's presence in their own lives and in the lives of families living with HIV/AIDS. Reflections on God's presence as presented within the ABDCE Model were also utilized as training materials for this exercise.

   The participants (co-researchers) described and interpreted these also by means of presenting a meditation.

Thickened through interdisciplinary investigation

This step is concerned with the development of interdisciplinary informed materials, which is added to the gained insights from the outcome of the triangulation of data sources, theory, methods and research participants.

6. *A description of experience, thickened through interdisciplinary investigation.* A dialogue with other disciplines, for example, social work, family therapy, psychology, anthropology, theology, and social economics, with the intention to integrate the various stories of understanding into one. In this study the participants (co-researchers) will design and discuss narrative case studies, guided by literature from various disciplines. The cases are based on the arrived at themes and analysed discourses from the ABDCE Model.

Point six is consistent with phase five of the Intervention Research Model.

Interpretations that point beyond the local community

7. *The development of alternative interpretations that point beyond the local community.* The development of alternative interpretations, through deconstruction and emancipation, with all the co-researchers, herewith developing a new story of understanding that will have possibilities for broader application. In this study, through triangular reflexivity, the ABDCE model developed a broad spectrum of collective understanding and meaning, of which the preliminary training material is an outcome. The participants (co-researchers) in the pilot studies, who lived, strengthened and spoke about the intervention, as developed by use of the training materials will set out to practice the learned pastoral family therapeutic skills to provide care and counselling to families with HIV/AIDS. The participants are empowered to deconstruct negative discourses in their church communities, based on their new understanding and created meaning. The researcher will provide concentrical dissemination, starting the training in her own community and then will take the training programme beyond her local community into other communities of faith (Muller 2005).

Point seven is consistent with phase six of the Intervention Research Model.

2.5 OTHER METHODOLOGY USED IN THIS STUDY

Because it was important that the co-researchers gained understanding of prevalent dominant discourses in the lives of families and (church) communities living with HIV/AIDS, they needed skills to assist them in identifying these discourses. The training materials would need to assist church leaders and lay counsellors to help families and communities living with HIV/AIDS to be enabled to deconstruct and re-construct social meaning and live their preferred life stories.

Deconstruction and re-construction of social meaning

Social constructionist research speaks of social constructs as described and created by the language that participants (co-researchers) are using.

The researcher listened to the narratives and language used in conversation with research participants. The researcher followed a process of de-construction and reconstruction of social meaning and used the following steps derived from the definition of discourse analysis:

"Discourse analysis can be defined as the act of showing how certain discourses are deployed to achieve particular effects in specific contexts" (Terre Blanche, et al 2007:328)

- Identifying discourses that operate in text
- How particular effects are achieved in text
- Explicating broader context within which the text operates

The researcher explored the different linguistic possibilities where solutions, or 'unique outcomes' can be individual or communal and lead to personal, family and communal action.

Kunneman (1997) qualified qualitative research in postmodern society as a normative activity, whereby the researchers practice reflexivity towards the content questions and normative and existential dilemma's of the research

participants, e.g. the quality of their lives, the content of their practice, its broader cultural and societal context and the quality of their actions. He mentioned the rationality of the researcher and the rationality of the research participants integrating the hermeneutic understanding and narrative transformation within their practice. The person of the researcher and the communicative quality of their relationship are significant for the research outcome (Kunneman 1997).

2.6   RELIABILITY, VALIDITY AND TRUSTWORTHINESS

Ethical considerations in a general sense are the objectivity, reliability, internal validity, and external validity of the study (Lincoln & Guba 1985). In this study methodological objectivity is maintained in doing justice to the participants of the study, by observing them within their familial, historical, cultural and social context. The participants are also viewed as people with their own psychological make-up, theories and dynamics. The objectivity of the researcher is not perceived as neutrality, but rather as making a reflective, intelligent and positive use of their own subjectivity (Maso & Smaling 1998).

Internal validity refers to the validity within the research study. In this study internal validity is maintained where the research participants were taken through a process of being widely and deeply informed and therefore reached a point of climax, of shared new understanding, based on narratives of action, reflection, and interaction with scientific disciplines. The participants have been writing notes, attended discussions, in some instances underwent initial interviewing training, spoke with other 'outside' professionals and reported their initial findings to different audiences. The method of triangulation also added to the internal validity.

The external validity refers to the "trackability" of the study. In this study, the external validity was maintained where the status, position and roles of the different research participants and informants is described, as well as the

situation, conditions and context of the study itself. The external validity is also maintained where the theoretical underpinnings have guided the choice of methodology and therefore the transferability of the arrived at training model. Kelly mentions in this context that "consciously acting from a particular standpoint does not mean that we are not genuinely and rigorously enquiring" (Kelly 2007:382).

Specific ethical considerations are mentioned in Chapter 5 as part of the description of each of the research findings.

2.7   <u>SUMMARY OF ETHICAL CONDITIONS</u>

The different phases of the study involved various ethical considerations as discussed above and are summarized hereunder:

In the analysis phase the research involved work with persons living with HIV/ADS and persons who were indirectly involved with HIV/AIDS. Both sets of respondents were treated with the utmost respect, their anonymity assured, confidentiality respected and the research project clarified at the outset. They were definitely regarded as co-researchers and afforded due recognition. Expectations were clarified and they were appraized of the possibility to withdraw participation at any stage without penalty.

Painful issues that surfaced during the research process were dealt with empathetically and therapeutically as deemed necessary.

Phases two and three involved secondary data sources, so ethical considerations were mainly in respect of accuracy in and authenticating of data interpretation.

Phase four involved the pilot study with research participants, and similar ethical issues to phase one were respected. In addition, a supportive and non judgemental atmosphere was maintained to allow for optimal learning.

The study with its ethical considerations also received ethical clearance from the University of KwaZulu Natal, under whose auspices it was undertaken.

2.8   <u>LIMITATIONS OF THE STUDY</u>

General limitations of the present study included the comprehensive body of information and different data sources that was time consuming to collate. In particular, very careful attention had to be paid to ensure trustworthiness of the data. However, the richness of the gathered data was clear and allowed for multi-partiality, a core ingredient of the study.

The data gathering was mainly done in KwaZulu Natal, which limits the generalizability of the study to other areas. If the study had extended to other provinces, different dynamics, themes and problems may have come to the fore.

Language was experienced as a barrier during one of the focus groups with Church leaders from a rural area. The conversations took place in IsiZulu and although it was fortified by much nonverbal communication, the researcher was not able to understand all of the spoken language (summarized on her behalf) and could have lost some of the content through the translation process.

Since some of the participants were known to the researcher, they may have not been altogether forthcoming in sharing all their experiences, so as not to jeopardise the relationship. Alternatively, it is possible that the long standing relationship yielded rich, sharing with the researcher, which appeared to be the case in this study.

Some of the participants were already attending HIV/AIDS training programmes and therefore their views may not reflect the views of people who have no exposure to such training. Thus, generalization of results needs to be guardedly undertaken.

2.9   <u>TIME FRAMES OF THE FIELD WORK</u>

The period when the fieldwork for this study was undertaken was from 2005 till 2008.

CHAPTER THREE

LITERATURE REVIEW : ACTION AND REFLECTION

3.1   INTRODUCTION

The literature review is part of phase two of the Intervention Research Model which deals with the information gathering and synthesis and uses information from literature, from studying natural examples, and from identifying functional elements of successful training models.

The title of Chapter three refers back to the necessity of interacting with the activities, routines and beliefs of HIV positive families. The background to and reflection on the interaction of the church communities with these action fields of HIV positive families and the unique outcomes are discussed to help inform the development of the training model.

In this Chapter the researcher will discuss the following aspects through a thorough literature search:

- describe the life world of families living with HIV/AIDS, focussing on the life world of highly affected and often neglected families, e.g. skipped generation families, child headed families and families of gay and lesbian people.
- describe the role of the churches, their history, and present involvement in the life world of HIV/AIDS affected families.
- describe and interpret in-context experiences of families living with HIV/AIDS, in the form of narratives, based upon the metaphor of narrative writing as

described by Anne Lammott, (as explained in Chapter Two) namely Action, Background, Development, Climax and Ending.

- identify and describe specific discourses and traditions within families, communities and the churches which inform their perceptions and influence their behaviour related to people living with HIV/AIDS.
- describe the conversations of several disciplines, e.g. theology, social work, and family therapy, regarding their theoretical and practical stance in relation to families living with HIV/AIDS.
- describe contextual and narrative family therapeutic approaches in counselling families living with HIV/AIDS and relate the outcome to the family therapeutic and community orientated context of practical theology.

Thus, literature will be used to richly describe all the above-mentioned key aspects.

3.2   FAMILIES LIVING WITH HIV/AIDS

3.2.1 Introduction

The following section provides a description of the life world of families living with HIV/AIDS in the (church) communities in Southern Africa. Specific attention is given to the life world of orphaned and vulnerable children, e.g. the child living with HIV/AIDS. A description is provided of the life cycle of people living with HIV/AIDS and the challenges they are facing.

3.2.2 Families Living With HIV/AIDS

HIV/AIDS is a family disease (Belsey 2005). Awareness and protection, infection, care, support, economic impact, illness, death, stigmatization… all is experienced within the

family context. The effect extends to an intergenerational impact on family structures, family functioning and family wellbeing (Belsey 2005).

Support structures within the family and in the community are essential to protect and support infected and affected family members and enable them to function and cope better with the impact of the disease.

Churches are part of the community safety net, specifically where extended families experience stress as a result of both a dramatic increase in the added number of orphans and a decrease in the number of primary care givers, who have died (Pharoah et al 2004). Another vulnerable family group are families of gay and lesbian men and women, who are often having to deal with more than one stigma presented in their (extended) families and communities.

The orphaned and vulnerable child in the family.(African) Christians are by birth and name-giving incorporated into their families as well as being incorporated into the church through baptism. Both are covenants representing the core of relationships, person to person and community to community. Oduyoye mentions that living according to the Christian covenant means to be truthful members of one another and conform to the values of the Kingdom of God e.g. communal, yet personal caring, regarding other people and accepting what they offer to the community. The Eucharist, is interpreted as sharing of what really costs us something, this being a living experience for African people and the way to replace charity with justice (Oduyoye 2000:119). Balswick and Balswick (1999) also characterize the covenant as a commitment of unconditional love at the core of family relationships. This is described as an upward spiral, meaning the security provided by love, which develops grace, and the freedom to empower each other, which leads to the possibility of intimacy between family members. God desires all people to be in relationship with the Creator as well as with each other (Balswick & Balswick 1999). Orphaned and vulnerable children, as much as being born into a family, would then be at risk, not to receive this covenantal love and support within their families of origin, which impacts on their wellbeing and development.

The researcher will apply the work of Erik Erikson and James Fowler, concentrating on specific developmental processes and Biblically and culturally defined life stages, as also described by Donkor, e.g. creation, conception, birth, education, ethical existence, generativity, eldership and death (adapted from Ephirim-Donkor 1997). These stages are predicated by a Biblical worldview, which has its ontological basis in God (Yahweh) and the trinity of God the Father, Christ the Son and the Holy Spirit. Fowler mentions that people are reflective and responsive members of creation, capable of partnership with one another and with God. These deep-structuring potentials, can be thwarted and distorted by the misuses of freedom by others that affect us, and from our own misuses of freedom. This can lead toward resistance to God and toward competition and defensiveness towards the neighbour. Fowler mentioned that selfhood is formed and faith awakened in relation to others and to the culture of shared social meanings and institutions, a matrix of relationship, language, ritual and symbol. Embodiment, reflective conscience and thought are developed in our relationship with God, creation and the neighbour (Fowler 1987). Capps used Erikson's eight psychosocial stages of human development to clarify the work of the pastoral counsellor. These stages are perceived as a cyclic process, incorporating the individual, generational, and the social life cycle. According to Erickson, the stages consist of a positive and a negative pole and what counts is the ratio between them, e.g. if a person has no mistrust at all, he would be poorly prepared to function in a world with its evils (Capps 1983). Therefore, in the researcher's view, families living with HIV may find that their psychosocial modalities, their perspectives, and capacity of actively engaging in their world, have changed. The researcher will discuss the life cycle stages related to the development of 'the self' in relation to being HIV positive.

Life cycle stages

1. Infancy. After conception, the HIV virus can be transmitted through the uterus, at birth or through breastfeeding. Families are caring for infants that are asymptomatic or ill may have access to antiretroviral drugs and need monitoring throughout. The world of the foetus and infant is threatened by risk of infection, insufficient health care and inability to build sufficient trust and loyalty in primary

relationships, the 'to get' and 'give in return'. To be in the care of trusted 'adults' is vitally important for the healthy emotional development of the infant. Death itself cannot be understood, but the loss of the familiar, e.g. voice and smell can cause great distress to the child (Willis et al 2005).

2. Early childhood. HIV-positive children that are sick may experience stunted development and do not receive sufficient stimulation as the pre-occupation of their caregivers is with the child's ill health or their response to the treatment. Often the condition is hidden from the neighbours and therefore the child is hidden and doesn't learn to differentiate from its environment. The child is shamed and becomes subdued to the will of the caregiver, confused as it is not allowed to develop self-will and explore its world. Children this age cannot fully verbally express themselves, which may cause frustration to the child (Willis et al 2005).

3. Play age. The sick child may be hampered in developing initiative to be 'on the move'. Sick children and children on ongoing treatment often experience stigma and discrimination within the family or from neighbours. The food and the attention seem to be unevenly distributed. Either these children become overly protected or they are neglected. The child may feel guilty for being perceived as a burden and transgressor to the family.

   Children at this age may have many questions and any threat to their body, e.g. investigations may cause anxiety (Willis et al 2005).

4. School age. From early childhood through to school age, children infected at birth, that are 'slow progressors' would only develop AIDS-related symptoms in these later stages. Sometimes children are only diagnosed when they develop symptoms at a later stage. Child sexual abuse can be a cause of infection and when children become sexually active upon reaching puberty. Sick children may not be capable of applying themselves to skills and tasks. School going children experience being stigmatised by peers and teachers and therefore develop feelings of inferiority in not being allowed a social status and opportunity to develop skills. At this age children can be overwhelmed by grief, which they experience in similar ways to adults (Willis et al 2005).

5. Adolescence. Adolescents and young adults are perceived as a high risk group for HIV infection. For adolescents their physical growth and genital maturity may cause confusion about who they are and where they fit in. Adolescents would form peer groups to help each other find their identity. For adolescents that have become sexually active through this process and have tested HIV positive, their whole new world and perception of self become compromised.

6. Young Adulthood. At this stage the young adult would form shared identities with others. Being HIV infected may cause the young adult to have problems with identity formation, becoming intimate with another person or for a couple living with HIV/AIDS, being infected may cause isolation.

7. Adulthood. The risk of HIV transmission has become significantly low, as in mother to child transmission with discordant couples or when both parents are on antiretroviral treatment. Therefore many HIV-positive couples take that risk and become pregnant. Generativity can also mean to invest in the next generation by caring for and nurturing others. Stagnation in this developmental stage would mean that adults become self-absorbed and don't invest in their children. Couples, who are living with HIV/AIDS, may also decide not to have children.

8. Mature adulthood. This stage is marked by endorsing of identity and letting go of our place in life. Accepting that death will put an end to our present identity. Older people in families living with HIV/AIDS may become the primary caregivers to their grandchildren and carry the sole responsibility for their upbringing. Despair is not so much seen with not being considered and respected, but more with the enormous task and their diminished strength.

The themes of being 'at home', 'fitting in' and 'completing life' are fundamental ways of being orientated in our world (Capps 1983). In the researcher's opinion, these are often areas that are compromised in the lives of orphaned and vulnerable children. Waruta describes the development of 'the self' from an African perspective. The infant strapped close to the mother's breasts, studying her facial expressions, being moved to her back and able to observe and explore a wider world, now also tied to the back of its siblings. When the child moves independently, it is constantly surrounded by kin, and learns

duties and obligations. The young person acquires life skills through observation and participation in family and community life, the internalising of values and giving of meaning through enculturation, e.g. story telling, dance, and counsel of elders and peers. Initiation rites would educate the young adult on issues of sexuality and values related to their own position and work life within the community context. Entering mature adulthood, men and women could be chosen into specialised roles, serving their community as priests, leaders, counsellors, midwives or healers (Waruta & Kinoti 2000).

Thus, it is apparent that when families are living with HIV, this process of development can become interrupted. The researcher believes that for many children, infected and affected by HIV infection, the world becomes a hostile place and their orientation is one of abuse and mistrust, e.g. street children. The life cycle also becomes interrupted when 'the letting go of our place in life', happens through all other stages and people living with HIV would not reach adulthood, or mature adulthood.

3.2.3 Highly Affected Families

In a recent South African study (Mturi & Nzimande 2006) about the link between changing family patterns and HIV/AIDS, the following unconventional family structures were mentioned mainly as an outcome of the HIV/AIDS pandemic:

- Skipped generation families. Parents in their middle ages die and the remaining orphaned children are cared for by their grandparents. The large number of orphans demands an increase in living arrangements.
- Child headed families. The elder child (often a teenage girl) takes care of younger siblings. Children as young as 11 years old have been identified as care givers. Work and responsibility is given to children sometimes as young as five years of age, e.g. domestic chores, subsistence farming, care giving, begging for food, getting supplies from neighbours. These children lack social, economic and emotional assistance and show insufficient life skills and lack of knowledge (Pharoah et al 2005). As teenage caregivers cannot apply for a grant themselves, and need an adult to assist, they may resort to prostitution or

working in the fields for the whole day, to support their siblings. Schooling for these children is often compromised (Mturi & Nzimande 2006).

In African society, due to economic migration, and unemployment, it has become a common situation that grandparents bring up their grandchildren, and sometimes receive remittance from their children. In traditional Zulu culture as well as in Indian culture, the family-group resided patrilocally and comprised of nuclear families under the authority of the founder (Vorster 1981). In rural areas, grandparents are still part of the extended family and live close to the often single parent family unit. Teenage pregnancy also needs to be mentioned as a reason for a child being raised by the grandparents whilst the mother is still schooling.

Thus, it is clear that there exist many different family types that need consideration when developing appropriate practice interventions and training models in the face of HIV and AIDS.

3.2.4 Orphaned And Vulnerable Children

In Sub Saharan Africa 12 million children under the age of 18 have lost one or both their parents to HIV/AIDS (UNAIDS & WHO 2008).

Orphaned children in general may lack basic resources, since usually love and support are provided by emotionally-invested caregivers, like family members (Simbayi et al 2006).

AIDS orphans are at greater risk of the following psycho-social and health problems:

- malnutrition due to food insecurity
- illness due to reduced access to health services

- early school termination, due to pressure to drop out of school, because the children are needed at home or money for school fees is needed for medical expenses
- stigmatization resulting in isolation and exclusion
- abuse and sexual exploitation
- deteriorating housing
- loss of access to land and other productive assets, e.g. the sale of life stock and land and asset stripping by family members
- psychosocial distress, e.g. loss of parental love and nurture, depression, grief response to parental illness and death, exhaustion of work and anxiety, insecurity, stigmatisation and separation of siblings among relatives to spread the economic burden of their care (Williamson 2000).

Vulnerable children are identified as (Simbayi et al 2006):

- Living with sick or dying parents. The family income decreases and many families go into debt and sell family assets in order to pay for healthcare and funeral costs. Migration takes place between households, e.g. when parents 'come home to die', caregivers (adolescents) and dependents move around to find the best care and support arrangements. Vulnerable children suffer trauma from the death of parents, siblings and others in the household.
- Living with a very old, frail or disabled caregiver in relationships of mutual dependency.
- Living in a mostly female headed household, where there are also orphans taken care of, and missing the income from the diseased breadwinner. The children experience reduced quality of life when resources are shared with relatives affected by AIDS and sick family members are taken care of in the home. Community resources may become scarce because of the AIDS epidemic.

Thus vulnerable children are clearly a feature of not only evolving family structures as discussed by Mturi and Nzimande (2006) but also by Simbayi et al (2006) where living conditions place children at risk. Intersecting circles of influence of family structure and

living conditions are herein apparent. Studies have shown that the total proportion of unsupported or exploited children, living in extreme vulnerable circumstances represents less than 2-3 % of all orphans in Southern Africa and only about one-third of these children will suffer negative psycho-social outcomes (Pharoah et al 2004). These studies oppose the popular assumption that impoverished, traumatised, marginalised children, without proper role models and supervision are more likely to become involved in crime, anti-social behaviour and group based aggression.

Studies of children's reactions to parental illness and death, loss of home and dropping out of school, separation from siblings and friends, increased workload and social isolation have shown internalised symptoms, such as depression, anxiety and withdrawal and not externalised behaviours, such as aggression or other forms of anti-social behaviour (Van Dijk 2001).

Children show remarkable resilience, related to e.g. their personality, temperament, coping style, age of exposure, social support, and opportunities for recovery. Relationships with caring adults can help children seek out these positive experiences in the midst of adversity. Poverty, separation, loss, bereavement and cruel and impersonal care, are determinants for poor psycho-social adjustment (Richter 2004). Family resilience work is described by Walsh in the areas of family belief systems, organisational patterns and communication-problem solving (Walsh 2003) and by Denis (2005) in the area of memory work and resilience with families living with HIV/AIDS.

Child participation is described by Kruger (2008), who designed and directed a project which set out to use children's insights and recommendations to improve their living situations at paediatric hospital wards and at paediatric step-down services (Kruger 2008).

These studies highlight the importance of incorporating issues concerning the life world of the HIV positive and orphaned child and child participation in the Training Model.

3.2.5 Families Of Homosexual Men And Women

HIV infection in Southern Africa has of late become increasingly known as a heterosexually transmitted disease wherein the 80's it was known as the gay related immuno-deficiency (Reddy & Louw 2002). The latter aspect has received minimal attention, so that presently, in order to also give attention to the impact of HIV infection on the gay and lesbian community, the 're-gaying' of HIV seems necessary. Research findings with black gay youth showed the need for focus on sexual and gender identity and the need to address the community at large about gay and lesbian issues related to HIV/AIDS (Reddy & Louw 2002). Shelver, responding to a homophobic article on 'the perversion of family values in same sex marriages' which was published in the Sowetan, mentioned the family as: 'essentially a unit that provides its members with love and support'. The apartheid regime caused exclusion and destruction of the African family and dictated who South Africans were allowed to marry and have relationships with (including same sex relationships). She argued that most of the care giving units in South Africa consist of a number of women, e.g. single mothers, grandmothers, without the men (Shelver 2000).

Kadushin (1999), in an American study, discussed barriers for gay men in receiving support from their families of origin. The study mentioned that gay men with HIV/AIDS are known to prefer partners and friends as sources of support to their families of origin. Earlier studies showed barriers as the family's rejection of the person's sexual orientation, the need for disclosure of their homosexuality and the stigma related to HIV infection. The findings of the study showed that the family provided emotional support and fun relaxation at significantly higher levels than informational and instrumental support. Mothers and siblings provided a significantly higher level of support than fathers.

Barriers to support that were mentioned by Kadushin (1999) included:

- Lack of knowledge by the family regarding HIV/AIDS, specifically the fathers, which meant that the relationship would not be beneficial.

- Fear of compromising independence, by asking his family of origin for assistance. Family members may be disregarding the man's physical condition, put blame on the person for being ill or show a pattern of overprotective behaviour.
- Family members of HIV positive men may live far away or be sickly, retired or elderly.

Men with AIDS perceive a lower level of barrier than men with HIV. The study suggested that the father's low level of support could be due to the father's conservative political and social values, showing negative attitudes toward homosexuality and gay relationships.

The interrelations of family support, family acceptance and family knowledge of gay orientation and gay male identity formation is apparent in this review of literature and is further discussed by Elizur (2001). Same-gender identity formation was defined as a process of:

1. Self definition. The new reality is shared with the social familial environment.
2. Self acceptance. The new identity is consolidated and HIV status were easier discussed with siblings than with parents and shared with peers (Kadushin 1999).
3. Disclosure. This encompasses leaps of disclosure and continuous dialogues with others.

Gay and lesbian youth were found at greater risk for mental health problems, e.g. major depression, suicidal behaviours, sexual risk taking, than their heterosexual peers. Unique stress factors were stigma, discrimination and violence, e.g. verbal and physical victimization. HIV-related symptoms among gay men and AIDS-related bereavement were mentioned as stressors that predict psychological distress (Elizur 2001).

Couples living with HIV may become nonsexual lovers, sometimes because partners become phobic about AIDS, or because living with the HIV virus has a negative effect

on their sex drive. Some couples settle then for an affectionate and caring relationship (Shernoff 1995).

Gay male widowers are often not recognized in their relationship, and in their loss by their partners' family nor by society. They are then dealing with disenfranchised grief and experience emotional loneliness. If the grieving widower is himself HIV-positive, his health can also be compromised. Gay men who grieve may become subject to homophobia (Shernoff 1998).

Many gay and lesbian adults appeared to have achieved a level of psychological adjustment and greater mental health, e.g. feelings of self-worth and wellbeing which are comparable to their heterosexual peers. This is more due to support and socialisation by friends and the gay and lesbian community than that of their families of origin. Elizur (2001) stressed the importance of viewing families as having reparative potential, instead of viewing families as damaging to the psychological wellbeing of the homosexual or lesbian family member. Affirming their reparative potential will draw their instrumental and emotional support.

 Families may also shift from initial crisis of disclosure to family acceptance and a more positive relational level. Findings suggested that families can play a positive role in the life of gay men, even in societies with traditional value orientations and mostly in the process of self acceptance and disclosure. Identity definition is usually hidden from one's family, in need of empathetic understanding from others 'who walked the way' (Elizur 2001).

In summary, families have added to the stigma and discrimination, both of same sex orientation, as well as the HIV status of gay and lesbian people. The above mentioned research studies show that when families are assisted with information and come to a point of acceptance, which motivates and enables to provide emotional and material support, their gay and lesbian family members will be less at risk for psychological distress. This important conclusion has relevance for the present study in searching for

training that will optimally address the HIV/AIDS pandemic for church leaders and lay counsellors.

3.3. THE CHURCHS' INVOLVEMENT IN THE LIFE WORLD OF FAMILIES LIVING WITH HIV IN THE (CHURCH) COMMUNITY IN SOUTHERN AFRICA

3.3.1 Introduction

The following section will describe some of the history of the Churches in South Africa and their relevance in response to the HIV/AIDS pandemic. Specific attention will be given to the African Initiated Churches, because of their size and influence in the lives of many black South African families. Further, the researcher will describe the activities of the churches related to families living with HIV/AIDS.

In the Bible, the church is described and experienced as being 'the bride of Christ' Christ bought her with His life (His death and resurrection) and left her with his Spirit, so that she can prepare herself for His return. This analogy speaks of the intimate and delightful union between God and his people, enjoyed both personally and corporally now and one day to be consummated in Heaven (Watson 1982). The word church (*kurike*), means 'belonging to God'. Another translation is *ekklesia*, which means a convened assembly of people.

3.3.2 History Of The English Speaking Churches In South Africa

De Gruchy (1997) writing about the history of the churches of modern South Africa, and specifically the English-speaking churches, focuses on the attempts of the different churches to unite, either within their own denominations or with other churches. In that regard, he mentions the emergence of the United Congregational Church of Southern Africa (UCCSA) in 1967, from the predominantly white and Coloured Congregational

Union, the Bantu Congregational Church and the churches of the London Missionary Society. In the new church only 10 % of the people were white. The Southern African churches, from the late 1960s mostly spread from Mozambique to Namibia and extended to Zimbabwe and Botswana. They also established links with international ecumenical organisations as the World Council of Churches (WCC) and their own international bodies, e.g. the World Methodist Conference. The churches presented all with distinct traditions of belief and governance, which gave each their own character, e.g. emphasis on Biblical authority, experience of personal conversion and issues of social behaviour. De Gruchy mentions that in the past, black political leaders, e.g. Albert Luthuli, were often active members of mission churches and protested against the racial discrimination built into the constitution of the Union, hence the start of the African National Congress, affirming liberal Christian values such as individual rights and freedom (De Gruchy 1997). At the time the ANC was critical of the unwillingness of many of the churches to speak out for equality and justice. They encouraged unity amongst the churches.

At the conference of the Christian Council of South Africa in Rosettenville in 1949, all the participating churches passed resolutions against apartheid legislation, but they failed to implement these in their common life and practice (De Gruchy 1997). In the white churches, some ministers and priests were increasingly playing a political role, e.g. Trevor Huddleston in the Anglican Church. Another important event was the Bantu Education Bill in 1953. State financial assistance was withdrawn from the mission schools. The churches lost their influence in black education.

In 1960 the Anglican Church appointed their first black bishop, so did the Methodist church in 1964. The Second Vatican Council of the Roman Catholic Church, held in 1962, encouraged a stronger commitment to social justice and the Geneva Conference on church and society (1966) called on Christians to directly participate in the struggle for justice, when there is oppression and revolution. The rise of black theology, starting in the 1970's when black students started their own student organisations, meant that black people themselves directed their own struggle for freedom (Klaaren 1997).

De Gruchy mentioned that black consciousness and black theology impacted the English speaking churches as a whole, whose majority were now black people, which influenced church policy. The World Council of Churches (WCC) established their Programme to Combat Racism. Many church people had been arrested, banned or deported. In the townships many casualties resulted in funeral services, where the churches and community organisations cooperated. The church became involved in the struggle within the communities. During this period the Afrikaans Reformed churches, continued their support for apartheid, whilst the WCC called for intensification of international sanctions.

By the 1970's some evangelical leaders, e.g. Michael Cassidy, played an important political role in working for national reconciliation.

The evangelical community formed a cross section of the churches and held to the evangelical doctrines on faith, grace and Scripture. At the same time, the charismatic movement, spread widely in South Africa. This movement seemed a reaction against the social and political activism of the mainline churches and filled the need for contemporary worship and spiritual community. Independent charismatic churches were formed. Churches held different perceptions of social reality and the task of the church in society, e.g. structural renewal and spiritual renewal (De Gruchy 1997).

In 1985 the South African Council of Churches (SACC) called on the churches to pray for an end to unjust rule. The institute for contextual theology presented the Kairos Document, which gave theological direction for transformation of social and political structures and the establishment of a just and democratic order (The Gruchy 1997).The document widened the gulf between those supporting the struggle and others following the status quo. The United Congregational Church developed a pastoral plan for renewal and mission. After 1986 The Mass Democratic Movement was often led by church leaders, e.g. Archbishop Desmond Tutu and coordinated by the SACC. After 1990, church leaders have been in the forefront of efforts of mediation, either dealing with faction fighting in the townships, and later in the truth and reconciliation committee.

In 1990 the national Conference of Church Leaders at Rustenburg, brought together church leaders of wide diversity, e.g. the African Independent Churches. These leaders sought to reach consensus on issues pertaining the witness and role of the church in the new South Africa. In 1992, addressing the Ethiopian Free Church in South Africa, Nelson Mandela spoke the following words: "The church in our country has no option but to join other agents of change and transformation in the difficult task of acting as a midwife to the birth of our democracy and acting as one of the institutions that will nurture and entrench it in our society" (De Gruchy 1997:171-172).

At present, In South Africa, the African Independent Churches are the largest of all church groups. The Roman Catholic Church is the largest single denomination.

The pentecostal and charismatic-style churches have become an important social force (De Gruchy 1997). Many of these churches are influenced by American and Australian authors and leaders of large sized, mostly evangelical churches who put strategies in place to manage and grow these churches better. These strategies put emphasis on self-organisation, human participation and community life (Herholdt 1998).

Roxburgh mentioned that in a post modern society "we need to distinguish between the need for a contextualized church and a theological critique of the context that is grounded in a different narrative" (Roxburgh 1999:252). He characterised these churches as relating to post modern culture by continually reconstructing their identities as they are embedded in the intellectual and social narratives of their context. Their focus seems on the new and the next, hence descriptions of churches as: "Next Church, a Church for the 21st Century, the Purpose Driven Church, the Church for the Un-churched" (Roxburgh 1999:242).

The language that shapes the reality of these churches does not reflect on the meaning and truth of 'the narratives of beginnings' and the tradition of the church. Anderson mentions a paradigm shift from "if you have the right teaching, you will experience God", to "if you experience God, you will have the right teaching" (Anderson 1992:21). A pattern of experience is followed by proposition (Anderson 1992). Religious experiences

become normative, as basic propositional truth, which are then recorded. Anderson relates here to a paradigm shift from modern theology to post modern theology. In modern theology truth was seen as an absolute proposition beyond our narratives, which preceded and dictated our religious experiences, which then became a mere illustration of God's truth. In the post modern position, truth is to be found within the narratives and religious experiences become the truth. In this context, Foucault mentioned that our own experiences and choices are elevated to the highest status, because they now become our reference for truth. This creates the man who makes himself and puts faith in himself (Rabinov 1984). Pop (1964) points to the pre-modern view in theology, where the truth was not some eternal law behind the events, but the fact that in the Bible narratives themselves we meet with the same God who deals with us every day as we live our life stories (Pop 1964). Wright refers in this context to Jesus' teachings, where His stories were not mere illustrations of truth, but ways of breaking open the worldview of his hearers so that it could be remoulded into the worldview that He was commending (Wright 1992). In postmodern theology God and men are seen as co-creators of daily experience (Herholdt 1998).

This notion is important to the study because many church leaders and lay counsellors have been trained from a conservative hermeneutic perspective, where the truth is found in what the author meant to say and is therefore authoritative. Training church leaders and lay counsellors with family counselling skills will draw on their personal and familial resources, their own life experiences and choices and will allow for reflection and truth seeking. Their daily walk with God would then bring the working of the Other into their life experience.

3.3.3 African Initiated Churches

The African Initiated Churches (AIC) have their history in different traditions, e.g. Anglican, Methodist, Pentecostal. Approximately 8000 denominations classify as belonging to the AIC (Hayes 1998).

The three main representatives are the Zionist, Ethiopian and Apostolic churches. Their independent existence stems from around 1900, when the Ethiopian church broke away from the European Control of the Methodist church. The Apostolic churches gradually broke away from the Pentecostal churches and the Zionist church that was founded by missionaries from the USA, was left to continue on its own. The Zionist church is known for its practice of divine healing, prophetic leadership and baptism by emersion. The use of medicine, both western and African is generally eschewed.

Within the AIC a distinction is made across the following churches:

- African Independent Churches, which originated in Africa, and are not linked to groups or churches outside of Africa for any form of support.
- African Initiated Churches, which originated in Africa, but may have affiliations outside of Africa.
- African Indigenous Churches, which exclusively hold to African ethics, culture and theology.
- African Instituted Churches, which were established and developed in Africa (Hayes 1998).

Tshelane (2000) describes the AIC as not only existing in rural areas, but also becoming more dominant in urban settings. They are known as the singing, praying and healing churches. Meetings are held in 'open spaces'. Worship services are perceived as the community experiencing God, as revealed by the Holy Spirit. Spirituality is experienced in the totality of a person's existence and provides relief from stress due to e.g. work or over crowdedness. Members are liberated from social deprivation, materialism, disease and enabled to experience their faith in a lively, joyful manner, serving God and taking care of God's people and attending meetings and festivals. The theology is enacted and has pentecostal, ecumenical, prophetic and apostolic emphases.

In some of the churches, the prophet would take the place of Jesus Christ. In most of the churches there is an awareness of national issues. Tshelane (2000) perceives contextual theology and enculturation as theological discourses that have helped to

understand the AIC spirituality. The spirituality is also understood through 'accompaniment', the visibility of the church, modelling and accompanying their leaders during important occasions. Some of the mature women fulfil the role of 'animation', whereby they act as prophets, healers and have a following. Healing deals with spiritual causes to physical ailments, restoration of family relationships, success in work and financial health. Tshelane mentions 'traditional motherly love' and memorisation of Scripture and song as important ingredients of AIC spirituality. Moral prescriptions, such as abstinence from sex often follow from worship or from seeing a prophet (Tshelane 2000).

Anderson mentions that the AIC provide a cohesive community, where people that live in modern South African townships and informal settlements find security and a sense of belonging. He mentions that contextualised Christianity has gotten to the heart of the culture and therefore becomes like a product of that culture (Anderson 1995).

According to Daneel, contextualisation is not "a simplistic adaptation to traditional thought" nor is it "accommodation in the Roman Catholic sense of the word", but is rather "an adaptation that, while displaying parallels with traditional religion, essentially implies a continuing confrontation with and creative transformation of traditional religion and values" (Daneel 1990:56).

Oduyoyo understands contextualization as expanding from the socio-religious to the politico-economic aspects of African life (Oduyoyo 2000).

This section thus highlighted the need for the African churches to be contextual and therefore be relevant to a changing society with a focus on politico-economic aspects of community life. The focus of the African Initiated Churches is on community cohesion, through joint care structures, and on the health and wellbeing of their congruants.

3.3.4 The Involvement Of The Churches With HIV/AIDS Affected Families

The following section describes the response of the Churches in South Africa to the HIV/AIDS pandemic. The researcher provided a 'state of the art' review using literature and the mapping report as prepared for the World Council of Churches Eucumenical HIV/AIDS Initiative in Africa in 2005 (Parry 2005). Many of the characteristics of the

Churches as described in their history have become a strength in their approach to this 'new enemy'. Churches united against AIDS are joining agents of change and collaboration. Both African Initiated Churches and the Pentecostal and charismatic community churches are characterised by their healing capacities and provide structured community life. The evangelical and the Roman Catholic community maintain a strong emphasis on dogma and promote abstinence messages, whilst at the same time putting care and counselling structures in place. In 2003 many South African church leaders signed a declaration resolving to fight HIV/AIDS, which was perceived as a modern day Kairos Declaration (Meskin 2006).

3.3.5 Churches And HIV/AIDS

In our rapidly changing world, church involvement in the community and understanding its place and role in the public sphere means constructive action and a genuine presence in keeping with its identity (Robinson 1997). According to Mbiti, African theologians are at home in the world of the Bible. Many African values are not in conflict with Scripture. Instead, their challenges are with our rapid changing world and its many social, political and economic challenges (Mbiti 1998).

One of these challenges is the risk of families becoming infected with HIV, a mostly sexually transmitted virus and the changes this has brought to the churches and society.

Church leaders have many a time turned to the 'preaching of the Word' and put emphasis on Biblical values and morality, thereby shielding themselves from dealing with the context and realities of postmodern society. In many churches, mentioning sexuality and HIV/AIDS has for long been a 'taboo topic' (Haddad 2006).

When a condition is mainly sexually transmitted and the church has not condoned pre-marital sex, nor extra-marital affairs, then the HIV-positive person is to blame. As mainly the women are church going, they became marginalised and stigmatised within the

churches. They are then no longer 'at home' and no longer 'entitled' to a position in the church organisations. Many pastors would preach about HIV/AIDS as a punishment by God for the sins of the people, and say that those who are ill have brought it upon themselves. These pastors often have limited knowledge about the nature, course and impact of the epidemic. HIV infected people become stigmatized and rejected and therefore withheld of the pastoral ministry of the church (Louw 2006). People living with HIV/AIDS may remain invisible to the pastors or they may find themselves preoccupied with other concerns of the church. Sometimes churches are concerned that they need to change their value system to a more liberal position and/or otherwise would be criticized by secular organisations (Van der Walt 2004). When pastors do not educate their youth on safer sex methods, they often believe that speaking about condoms in the church would mean that the youth and other unmarried people are supported in using them. Abstinence may have been suggested in counselling, but without confidence to discuss sexual culture and relationship dynamics (Nattrass 2004).

The researcher agrees with Haddad (2002) that women's heightened vulnerability to HIV infection, because of their biological disposition and the oppressive socio-cultural climate in the home and in society are often not addressed. Over the years, specifically when the pandemic enfolded, church leaders, but mostly women in leadership positions in their churches have become more open to approach the matter of HIV/AIDS in their churches.

In 2002, the circle of concerned African women theologians, which was launched in 1989, organised a Conference in Ethiopia with the theme "sex: stigma and HIV/AIDS: African Women challenging religion, culture and social practices".

The challenges were found in social practice, culture and myths, violence against women, poverty, justice systems and morality and religion (Kanyoro 2003).

The conference was a direct response to the World Council of Churches (WCC) Global Consultation on the Ecumenical response to the challenge of HIV/AIDS in Africa, which

was held in Kenya in 2001. The consultation outlined a plan of action for the churches to follow, with the intent to help existing programmes become more effective, efficient and sustainable and to attend to critical issues as sex and sexuality, exclusivity, interpretation of Scripture, theology of sin, and therefore promotion of stigmatization, exclusion and suffering of people living with HIV/AIDS. The plan asked Churches to re-think their mission, and transform their ways of working.

Action points were theology and ethics, involvement of people living with HIV/AIDS, education, training, prevention, care and counseling, support, treatment, advocacy, gender, culture, liturgy and resources (World Council of Churches 2001) and are significant for incorporation into training models that will address the evolving needs of women in the face of the HIV/AIDS pandemic.

3.3.6 The Churchs' Response To HIV/AIDS

Organizations throughout Southern Africa have risen to the challenge of HIV/AIDS mitigation and prevention efforts. Many of these organizations have recognized the churches as being strategically positioned in communities to render the necessary services.

These organizations are often overarching organizations, to which denominations and churches can subscribe. Many of them have provided substantial information and training materials, organized workshops and created accountability as they are represented by national or provincial coordinators who work directly with the churches. Examples of such organizations are the Ecumenical HIV/AIDS Initiative in Africa (EHAIA), the Christian AIDS Bureau for Southern Africa (CABSA) and the African Forum of Faith Based Organisations in Reproductive Health and HIV/AIDS.

Several denominations produced their own publications, e.g. the book: "*A pastoral response by Catholic theologians and AIDS activists in Southern Africa, findings of a Conference hosted by the AIDS office of the Southern African Catholic Bishop's*

Conference in 2003" and the book "*HIV/AIDS beacons along the way series*" was developed by the AIDS Forum of the Dutch reformed Church and the Christian AIDS Bureau.

Several mainline Churches, e.g. the Catholic United Congregational, Anglican, Methodist, Lutheran and other Churches developed denominational policies, relating to their theology, mission statement and action programmes in the fight against HIV/AIDS. Interdenominational declarations were signed, e.g. the Covenant Document at the All Africa Conference in 2003.

The South African Council of Churches (SACC) also involves the African Independent Churches and has set out to combat HIV/AIDS and networks widely, addressing underlying problems such as poverty, homelessness, illiteracy and gender inequalities (Meskin 2006).

3.3.7 Church Programmes

This part of the 'state of the art' review is based on the mapping report as prepared for the World Council of Churches Eucumenical HIV/AIDS Initiative in Africa in 2005 (Parry 2005).

The Anglican Church of the Province of South Africa (CPSA) focuses on stigma eradication via care, prevention and impact mitigation, as well as an abstinence programme, including VCT, and ART treatment support. Both programmes operating as NGO's, received overseas grants. In KwaZulu Natal, a Provincial Strategic Plan was sent to each Diocese in 2002. There has been an uneven buy-in from the dioceses mainly due to lack of basic skills.

The South African Catholic Bishops Conference AIDS Office consists of the Catholic Health Association, the Catholic Development and Welfare Agency and the Catholic Institute of Education. Every diocese has an HIV/AIDS coordinator in place.

Focus is on capacity building, food and nutrition, youth, project management and enhanced financial management. Programmes are aimed at prevention, awareness raising, education and life skills, circles of care, home based care, care for orphans and vulnerable children, VC, counseling, training. ART provision came in place since 2004 at 22 sites, through clinics and hospitals.

The Methodist Church of South Africa developed a strategy and implementation plan. Objectives are prevention, care, impact reduction and resource mobilization. The Methodist Connectional Task Force on HIV/AIDS asked for direct impact projects for HIV positive families, improving their quality of life. Documentation of projects showed medical supplies for opportunistic infections, shelter for battered women, perma-culture gardening, counseling, home based care, de-briefing and supervision of carers, prevention activities and sex education, de-stigmatisation programmes, support groups, orphan care, child-headed households, income generating and feeding projects, liaison with clinics and NGO's. According to HIV/AIDS programme implementers and coordinators, the churchs' programmes are often uncoordinated, under-resourced and under documented. This point is important when developing training models that promise effectiveness.

The Uniting Presbyterian Church of Southern Africa (UPCSA). In the context of uniting the Church, the focus is on poverty alleviation and care for HIV/AIDS widows and orphans. There is not yet a policy in place and given that poverty alleviation is a national governmental priority that remains to be successfully addressed, church policy and planning in this respect could well precipitate governmental policy and change.

The Evangelical Alliance of South Africa (TEASA)
Eangelical churches, networks, pentecostals and charismatics.
TEASA provides training resources for churches, mainly aimed at peer education and counselling of youth and students. They provide programme development services for member churches and ministries who wish to develop HIV interventions with an emphasis on abstinence programmes.

Almost all member churches and affiliated agencies have their own programmes in impact mitigation, awareness raising or preventative education. HIV/AIDS is still perceived as peripheral to the churchs' calling. Few specific policies on HIV/AIDS are in place. The more active churches are involved in home based care. The pastors concentrate their efforts on evangelism and lack a theological perspective on HIV/AIDS. Many of them still believe that HIV/AIDS is retribution for committed sin as discussed earlier.

The Evangelical Lutheran Church of Southern Africa

The Lutheran World Federation developed a policy on HIV/AIDS, which is adopted by all the branches. Member churches are to develop their own plan of action. HIV/AIDS coordinators are attached at every level, from diocese down to parish level. Each circuit has volunteers leading the health committees. Care projects are a day care centre, hospital, health and information centres and youth programmes.

The United Congregational Church of South Africa (UCCSA)

Each of the eleven regions signed the HIV/AIDS policy statement and has an HIV/AIDS coordinator, who has been trained by the South African Council of Churches. At synod level they feel that they are doing too little, but appreciate all the small local initiatives, developed out of compassion. Projects are the development of a UCCSA directory of activities, prevention and education, HIV resource centre, hospice care, day care centres, the milk fund for orphaned babies, weekend camps for orphans and vulnerable children, support groups, treatment ministry and income generation. Identified challenges are the need for a holistic model, addressing poverty, stigma and indifference and the lack of trained people.

The Uniting Reformed Church of South Africa. "Since the end of Apartheid, the church focus has tended to be on unification not on HIV/AIDS. Overall it is 'voicing' support but has made no budget provision for HIV/AIDS" (Parry 2005: 67). However Parry believes that there are pockets of groundbreaking programmes at grassroots level

that offer considerable hope in this direction but again with the absence of infrastructural support.

The African independent Churches. Parry (2005) points to the lack of training of many leaders, and the command of widespread support. "Lacking formal structures, they are much more difficult to tap into to ascertain their rituals and rights, as well as their attitudes towards HIV and AIDS and subsequent responses. Undoubtedly they too are as affected as any other religion and they need engagement" (Parry 2005:70). The need for training is herein abundantly clear.

In summary then, the characteristics of the churches, related to their described history and theology, seem to influence their response to HIV/AIDS. Some of the mainstream churches, e.g. The Lutheran church are highly organised and function with clear procedures at all levels. The evangelical churches seem less structured and more prepared to carry the prevention message in a dogmatic fashion. The researcher's personal experience of working alongside the African Independent Churches in the last ten years has given her a different impression related to 'approachability'. She can indentify more with Tshelane's description of the AIC (Tshelane 2000) because the many participants on Siyahlanganisa's HIV/AIDS training courses who represented the AIC, spoke openly about the life world of their families and churches, which were narratives dominated by grief, sharing of resources, comfort, singing and willingness to receive the information from the course participants.

3.3.8   Faith Based Organisations

The role of faith based organizations (FBOs) is described in this review, since churches are perceived and needed as community faith based organizations. The description of faith based organizations by the UNAIDS provided a benchmark for churches and the new strategic plan for religious leaders invited for dialogue on ethical orientation.

The researcher focused on the UNAIDS strategic plan, because it enables church leaders to reflect on their action, background, and opportunities for growth.

FBOs as defined by UNAIDS, are groups of individuals who have come together voluntarily around a stated spiritual or belief system that informs and guides their work together (UNAIDS 2005). FBOs range from small, grassroots organisations with a simple structure and limited personnel, to large global institutions with highly sophisticated bureaucracies, wide networks, substantial financial resources and significant human resources
FBOs are networks, governance bodies, social service agencies, faith based NGOs, congregations and projects.
FBOs can have the following characteristics:

- Ability to mobilize people and resources
- Organisational networks to reach rural or remote areas
- Good understanding of local social and cultural patterns
- Expansive infrastructures
- Established or worked in health care and education
- Resources of faith, hope, and compassion
- Influential in policy debates
- 'Natural' ability to promote primary behaviour change (UNAIDS 2005).

The strength of FBOs and religious structures can thus be described as substantial, diverse, influential, reaching deep into the communities, and as part of family and community life.

The researcher agrees with De Waal's description of FBOs in the fight against HIV/AIDS as multifaceted and including organizations spiritual, emotional, psychological and value-related issues (De Waal 2005). This notion is important when considering a training model that caters for al these dimensions.

UNAIDS has initiated action research, assessment tools and strategic planning frameworks for faith based organizations and provided materials on diverse and

relevant topics e.g. men who have sex with men, HIV prevention and care (UNAIDS 2005).

The challenges UNAIDS has described in working with faith based organizations are: the diversity amongst the churches, lack of organizational structure, conflict at all levels of the work and stigma and discrimination within faith-based institutions and communities (UNAIDS 2008).

Again, poor coordination with resulting conflict features as concern and needs redress along with issues of stigma and discrimination in the training model/s.

UNAIDS' approach to relate to these challenges is to create understanding, by engaging each religion separately to define their responses and by promoting open dialogue in order to learn from each other and therefore promote a value-based approach to partnership development.

As mentioned in the earlier chapters, partnership is crucial in ensuring appropriate representation of all contributing influences so that context-rich responses ensue from these considerations. The leaders are supposed to do 'in-reach' in their churches and 'outreach' into the communities. These activities would help overcoming stigma. Church leaders are also encouraged to build partnerships between faith and secular communities.

The study presented by the Oxford Centre for mission studies also provided an insight in the specific contribution of churches as FBO's (Samuel 2005).

A seven-country research report on the contribution of Christian congregations to combat HIV/AIDS at community level in 2005 by the Oxford Centre for Mission Studies mentioned that though churches and organisational agendas overlap, churches are contributing key elements which secular groups either cannot do or choose not to do. These include the number of volunteers, the communication networks in churches, the provision of peer support and positive peer pressure, ministry marked by resilience and joy, the element of prayer, a message of hope beyond death and the provision of meaning. There is a need to develop closer working relationships between FBOs and secular organisations, including governments. There is openness on all sides to

improving these relationships, though there still exist tensions such as the debate about contraception and condoms.

All these considerations need to inform the final training product.

The report mentioned the need for people who have the time to invest deeply enough in the lives of others to change their behavior and prevent infection. These are people who allow themselves to care genuinely for the sick, who stay with them to the death, grieve with their families and care for their children afterward. "In such grim circumstances, fighting such a relentless foe, the level of resilience, joy and hope widely observed among Christian HIV/AIDS workers by the re-searchers in our team is absolutely amazing" (Samuel 2005: 32) Prayer, while the one praying is physically touching the one(s) prayed for, demonstrates a very close personal identification. One of the research findings from Kenya and Nigeria was that topics such as sexuality, gender and health were not discussed in the Churches, neither would Churches challenge the traditional cultural views on these topics (Samuel 2005). The report mentioned the need for a positive, yet disciplined theology of sexuality and a social space where this can be discussed and integrated among peers.

 This is a key consideration for a successful training model.

Samuel (2005) also alerts to reluctance by the church in discussing sexuality. Indeed, the topic is often trivialized. Gender is also not discussed, because cultural definitions are not to be questioned. Also disease is not discussed because it belongs to the medical field and is not regarded as a theological issue. Therefore traditional cultural views of sexuality, gender and disease were only condemned by the churches and not engaged and therefore stigma was maintained, not allowing sexual behaviour to change (Samuel 2005).

These issues need to be actively confronted in an era of HIV/AIDS, changing definitions of family and contexts that vilify alternate sexual orientations.

3.4   IN-CONTEXT EXPERIENCES OF FAMILIES LIVING WITH HIV/AIDS

In this section of the research report, the researcher listens to, describes and interprets in-context experiences of families living with HIV/AIDS, in the form of narratives, based upon the metaphor of narrative writing ABDCE formula as described by Anne Lamott (Muller 2003).

- '**A**ction', the researcher will describe the actual story
- '**B**ackground' the researcher will present the dominant discourses as the setting of the story in its cultural, socio-political and economic context
- '**D**evelopment' the researcher will look for a unique plot to develop, as the integration of the actual story and its setting
- '**C**limax' the researcher will look for the moment of the unique outcome
- '**E**nding' the researcher will describe what the story has left us with

This is part of the information gathering and synthesis process, as described under phase two of the overall research design employed in the conduct of the study, the Intervention Research Model (De Vos 2001:385).

The researcher wants to develop a greater understanding of themes and prevailing discourses in the lives of families living with HIV/AIDS as presented in the literature, in order to design training materials that are relevant in counselling families with HIV/AIDS.

The researcher made use of three different sources of literature:

1. Stories written by authors from Southern Africa
2. Stories told by eye witnesses from Southern Africa
3. Stories of face to face interviews with families with HIV/AIDS from Southern Africa

The researcher selected the stories from these sources based on provision of a rich description of the life world of families living with HIV and description of their discourses

in society. The researcher grouped the stories according to the 'theme' of their dominant story and selected two stories per theme.

All three data sources were considered important for use, with the data providing different perspectives of the problem, allowing for data source (tools) triangulation.

Description of the sources:

1. **Nobody ever said AIDS: stories written by authors from Southern Africa**

The book made use of 'creative writing' to allow stories of people living with HIV to be heard by the public, and in doing so to provide a sense of community (Rasebotsa; Samuelson & Thomas 2004).

The stories provide insight into the social and interior worlds of families living with HIV, in order to create empathy and new ways of addressing the pandemic. The following questions were asked by the authors:

What does it mean to live in a society where so many young people are dying? (*meaning* question)

How has HIV/AIDS affected the ways in which we live and love and express our desires? (*action* question)

How has the pandemic changed our understanding of the world we inhabit and the possible selves we can be within it? (*discourse* question)

2. **A broken Landscape : stories told by eye witnesses from Southern Africa**
    (Mendel Kaleeba & Byamugisha 2001).

This account contains stories that emphasize the strength and capacity of individuals, families and communities to fight back and be transformed in their response to the AIDS

pandemic. The courage of people in disclosing their HIV status and through their openness, provide life and hope for future generations.

3. **Stories of AIDS in Africa Face to face interviews, by international journalist, who lived in Africa for a period of six years** (Nolen 2007).

These stories were written by often long term engagement in people's lives. They tell of the struggle to stay alive, suffering major losses, betrayal at personal and communal level and stories of care for sick families and orphans, advocacy for rights and treatment, overcoming shame and fear through disclosure. The author provides action field, background, dominant and alternative stories, and seeks to answer philosophical questions in order to find ways to combat the virus.

- why we do the things we do (action)
- why we believe in what we believe (discourse)
- who we are and what we value (meaning)

The stories make society aware of the necessity to confront issues of sexuality, access to treatment, inequity as well as poverty and in doing so, extend beyond the family and community to social issues and contexts of the pandemic.

The first two stories tell about the experience of grief because of losing loved ones to HIV/AIDS.

Hereunder, themes are presented that were considered appropriate for extraction and learning, to inform and guide the training model/s, as follows:

Bereavement

1. **Milk Blue** - 'Art can bear witness to love and loss that has been rendered publicly ungrievable' Representing loss to others in the form of public art memorials' (Jamal 2004:40).

Table 3.1. ABDCE Outline for the story "Milk Blue" (Jamal 2004).

Action	Ritual for 31/2 months of once a day opening the bedroom door, not to enter, but study and contemplate on what he sees after his partner died. He is an artist and describes with colour, texture and images. Basin & sponge: care provision to partner dying of AIDS. Colours: milk & blue provide comfort, spilt milk, can see his partner and grief. Thin thread of dark: partner's unfaithfulness leading to death. Content of the room stays out of reach, needs time to grieve, does not respond to the outside world. Then sends the gallery an image projecting their relationship (2 synchronized wall clocks – subtitled : perfect lovers) affirmation of same sex relationship in the catalogue gives gratification. At exhibition second hand of clock fraction out of synch. Seems to him that no one cares. At night prays to God, sees oneness with Him. Contemplates that they were not alike, their hearts never one. Asks God's forgiveness: blindness, inadequacy, desolation. Humbled as he understands love to give and take away. Makes photograph of the bed. Picture: testimony to illness, death, love, loss. Puts down picture of partner whilst healthy, cherishes his features as they were nearing death. Makes picture of the bed available to the gallery and to be placed on billboards. He opens the curtains.
Background	Story about **homosexual relationship**, as HIV infection in Southern Africa is perceived as mainly heterosexually transmitted, stories about homosexual relationships are not easily available. Story about gay partner relationships, one faithful partner, one promiscuous partner. Promiscuity tolerated, non- discussed and non-resolved, causing hurt and feelings of incompetence to the older faithful partner. In South Africa gay partner relationships perceived as promiscuous. Acceptance and understanding of the quality of gay relationships in the artistic world as one of unity, understanding and physical pleasure.

	Story about HIV-infection, disclosure, transmission, illness, non-adherence, care giving, dependency in relationship, death. Story about lack of reciprocity, his partner not being there for him when he dies Story about **grief and bereavement**. Articulated through symbols and symbolic action.
Development	Truth seeking behaviour. Colours speak of non-judged life, his belongings speak of his controlled way of caring, seeking to keep alive. The perceived quality of their relationship. The enemy (promiscuity, death) who rings right. No sameness. Through prayer, acknowledgement of a God, confession of his inadequacy, inability to save his friend, to feel desolate whilst friend being in better place. Expressed need for a God opposite death. Love that gives and takes a way.
Climax	Acceptance of difference in personality, attitude, lifestyle, acceptance of self, Acceptance of his love. Freedom to disclose and carry on with his life
Ending	Making his findings public as art memorial. The world to bear witness to love and loss that has been rendered publically ungrievable A message to others to protect their lives?

Bereavement

2. **Leave- taking** Sindisiwe Magona is faced with complicated grief, the enormity of the task of bearing witness to suffering and of facing loss. Whole families are decimated, ceaseless suffering and loss
(Magona 2004).

Table 3.2. ABDCE Outline for the story "Leave-taking" (Magona 2004).

Action	Story of family of parents with 5 children, who in a short period of time lose 3 of their children to AIDS. The mother is a prominent leader in her church, she had asked for more openness and education for the youth which was diverted and denied. Her daughter became pregnant, and had an abortion, as she was found to be HIV- infected. She married young. The husband, a medical doctor, became protective over her and her health. The funerals were held in a traditional communal manner. The father spent much time in the shabeen, the mother became angry with her son-in-law as she was denied disclosure about the 'how' of the transmission, and access to her daughter was limited. When her daughter died, she kept silent and did not eat for seven days and then at her tomb cried out "God- I hate you"
Background	Story of position of women in the church in Southern Africa. Often a strong hierarchy where women can be in leadership positions but are subjected to their superior male and female leaders

Story of silence, euphemism and gossip in the church community. AIDS called 'the disease of the children' . Sex education means 'talking dirty' in the church. Traditional African culture did provide sex education for girls and boys by designated members of extended family. The word "Aids" not to be mentioned in the realm of prevention (in the church) , care (in the home) and disclosure (to the community) as it stigmatizes parents and the community about how they raised their children.

Story of protecting new found freedom in democracy. African invaders who now, after taking our jobs, etc. brought AIDS to South Africa

Story of culture of funerals. Samp without beans, feeding the guests, uninvited 'vultures' Mother to sit on the mat on the floor in her bedroom, the ongoing singing. The tent in front of the house.

Story of illness and grief being compromised by denial, secrecy and fear. Power struggles over the heads of the sick about decision making, care giving, disclosure Compromised health of the carers, the 'madness' of siblings being ill and dying at the same time

Story of role of the pastor, church not to be involved in prevention, education, or |

	counselling support, emphasis on church going, activities and financial contributions. No attempt at grief counselling. Pastor creates comfort zone of familiar words and the existing support structure. Story of mother and daughter relationship, cultural beliefs: loyalty "to be the wife of a husband is to endure hardship' New culture of boundaries: couple relationship and extended family. Betrayal and guilt : if only…motherly instinct to protect. Process of disclosure within the family, dealing with fear and shame. Perceived herself to be more affected as she gave birth to them. Also memories of openness and loving kindness in their family. Story of conversation with God and expression of anger as God betrayed her. A cruel, unfeeling, unforgiving God. God's curse on her life.
Development	Ongoing isolation of the mother as she communicates with each person and seeks to find a measure of control. When everyone pushes her out of their lived realities: her sons dying of AIDS (she gave birth to them), her daughter being infected, (she advised her to wait), her son in law (remorse might have brought forgiveness, and closure) the women group, (she has information to give) church (she blasphemed God) society (stigma) her husband (does not grieve the same way). She realises the fakeness of her world, except from the real meeting places with her children before they die, their affection and the love of her husband and some family members.
Climax	Complete silence, after which she is expected to 'start feeling better' and regain her duties at church and pay her share. She abandoned God.
Ending	Most likely this woman will go back to the church, estranged from her husband, absent minded to her last two children and suffering from **complicated grief.**

Both stories present multiple realities in dealing with grief and allow the reader to appreciate the process of grieving, complicated by the devastating reality of HIV/AIDS, the psychological make up, societal roles and ethical considerations of the key roleplayers as well as their personal dealings with God in the context of societal stigma and taboe.

The next two stories tell about strength and pain in disclosure of the HIV status, issues that have featured throughout the literature reviewed thus far and refer to the resilience and peer support of HIV positive people in the midst of ongoing stigma and discrimination.

Disclosure

3. Mzokhona Malevu   (Malevu 2001).

Table 3.3. ABDCE Outline for the story "Mzokhona Malevu" (Malevu 2001).

Action	Family of parents with 8 children and 11 grand children living in 2-roomed shack in squatter area. Mzokhona is 29 year old, living with HIV. Both parents work, live in impoverished circumstances. Lack of water for washing, no more access to treatment. Disclosed to family and community. Spoke to hundreds of people at candlelight service. Decided that he wanted an AIDS education funeral. Thanked his caregivers before he died. Family very upset.
Background	Authentic story of family losing their home during political violence in 1992 Story of lack of resources (7 children sleeping on the floor) and making the best of that at the same time being aware and expressing dismay that in other countries treatment is available and people don't die. Story of disease progress: Mzokhona developed blindness, and meningitis, which made him lose his mind Story of effective voluntary counselling and testing and ongoing counselling by AIDS counsellor from the clinic. Story of **purposeful grief,** where the family followed their son's instructions and educated the community at his funeral
Development	Young man who was loved by his family & community and contributed to the prevention of HIV-infection by addressing infected and affected. He could not save his own life, but did all in his power, in life and death to save the lives of others through education. Poverty and lack of resources has cost him his life.
Climax	The preparation for his funeral and AIDS ribbons visible on the photographs
Ending	Mzokhona died and his story and message stayed alive.

Disclosure

4. Prisca Mhlolo's story of inventory of fear and shame and hurt. (Nolen 2007)

Table 3.4. ABDCE Outline for Prisca Mhlolo's story of inventory of fear and shame and hurt (Nolen 2007).

Action	Prisca married age 23 as a virgin, she found out her status when her third baby was always sick. Diagnosis thrown in her face by nursing sister... Husband told her AIDS doesn't exist, white man's disease. He agreed to be tested. Doctor gave the child two weeks and her three months to live. Husband threatened her to never speak about HIV/AIDS. He was an army man and possessed rifles. He paid the lobola and also possessed her. She gave away her clothes. Her husband became controlling. Prisca felt isolated with her secret. Four years later she read about a support group and went along with her HIV positive child. Joined the group. Husband brought her daughter gifts. She admitted her child to a hospice with Kaposi Sarcoma. At the child's funeral the father became hysterical and progressed rapidly to full blown AIDS. He apologized for killing his child and being promiscuous. Still asked her to keep it quiet. Husband's family accused her of bewitchment. She first cursed her daughter and now her husband to get his money. They removed him and all their belongings. He still asked her not to disclose. He passed away. She found to be six months pregnant, he insisted on unprotected sex. She aborted the pregnancy and had no way to support her two children. Started to prostitute herself. Her support group sent her on a counsellor course and she became a VCT counsellor. Then her second son committed suicide as he was sexually abused by a teacher and was certain to be infected with HIV. She decided to become open and read her son's letter at his funeral and disclosed her status. Her siblings physically attacked her, leaving her with scars. Her mother became hospitalised with high blood pressure and refused to see her daughter. She disclosed on television and received more physical harassment from her family and also her neighbours shunned her. Then one by one her siblings died of AIDS and her mother approached her for financial support to grow her crop.

Background	.
	Story This authentic story took place in Zimbabwe. Prisca was diagnosed in 1987. The interview took place in 2006.
	Story of happy marriage which changed in family violence as accepted in society. Lobola means ownership and access to unprotected sexual contactof forced secrecy and denial. Keeping up the status quo of 'normal' family for the neighbourhood
	Story of hospital personal being judgemental and uninformed
	Story of caring for an HIV positive child, from early infection to death.
	Story of the myth of witchcraft. Easier to believe than illness and death caused by a virus.
	Story of family loyalty and importance of family rituals done at the graveyard for the dead
Development	A woman's journey of obedience to her husband, loyalty to her family of origin, prioritizing her child's health whilst maintaining secrecy. **Isolated grief**, finding support within confidence, paying reference to the customs of her clan.
Climax	Breaking the silence and telling the truth about her status first to her family and then on public television.
Ending	Prisca has become an outspoken counsellor and advocate for people living with HIV in Zimbabawe

The above mentioned stories give the reader insight in the enormity of sorrow, due to familial ignorance, traditional cultural interpretation and denial of reality. Both stories present with the severe cost of living through stigma and denial, illness, death and lack of resources. The stories also mention the resilience and consistent motivation to find peer support, address the issues at hand and make a public appearance even by means of one's funeral.

The next two stories tell about the complexity and reality of illness, life and death.

Denial

5. **Girls in the rear–view mirror** – Explores the relationship between truck driver and sex worker stereotypes reducing both sex workers and truckers to faceless members of risk groups. (Hall 2004).

Table 3.5. ABDCE Outline for the story "Girls in the rear-view mirror" (Hall 2004).

Action	Truck driver, wife and 2 daughters, introduced by family member to prostitution on the way. Description of girls surrounding the trucks. Hesitation, notices a girl that he falls in love with. Love relationship with her for some years. Other prostitutes for sex. Once seen a person dying with AIDS and became scared. He doesn't see the girlfriend for a year, eventually she comes back. He travels with his nephew, and is aware that he does not have a son. She looks ill and thin. There is apprehension, she touches his cheek and disappears. He gets angry at the fact that her (inner) strength has been taken away from her. Gets drunk, forces a girl to have sex, she doesn't ask for a condom as he is drunk and looks violent. He pays her well. Next day girlfriend has asked for him. He is scared and leaves. She contracted AIDS, went to her family, had her baby, who tested positive and wanted the child to be cared for by him. On the way back he is presented with a baby, his son. The girlfriend had died. He takes the child and stops on the side of the road and leaves the child to die under a tree. Carries on his journey home with his nephew next to him.
Background	Story of culture of truck drivers, being presented as male family members and people who work, care, think, look for and are introduced to entertainment and 'love' Story of relationship based on personal attraction Story of denial of risk for HIV infection and refusal of condom use. You can afford to pay more for 'real skin' Reasoning: 'never used it before, why use it now". The man with AIDS filled him with fear of exposure and risk of transmission. As much as he knows the information about condoms, he refused to connect that to his girlfriend and others. Story of murder. Initially accepted the situation, realised how much he loved the girlfriend and that she wanted the baby's short life to be happy and

	therefore came and died at the truck stop. The man bonded with the child, who looked like his mother, but had no resources could not face to bring it home to his family where it would not be treated well and the child would die soon anyway. He made it comfortable and left. Story of despair. Married to woman he doesn't love and who did not give him a son. Girlfriend whom he loved and gave him a son, but she died and the son would also have died. **Story of grief and living a life of secrecy.**
Development	Unprotected sex, leading to pregnancy and HIV-infection, illness, death and murder.
Climax	Realisation of his girlfriend's love for him and his love for her. Spoke it out in the presence of the child. Then did not owe up to his responsibility towards his son and left him behind.
Ending	The man grieves, clinging on to the girlfriends dress. The nephew turned his head and looked the other way.

Disclosure

They should not see him (Dube 2004).

Table 3.6. ABDCE Outline for the story "They should not see him". (Dube 2004).

Action	Husband home to die of AIDS does not want to disclose to anyone. Wife taken compassionate leave to care for him. Told his friends he's on a trip. His 9 year old son comes home after school and goes to family in the weekends. He is very fond of his mother, picks up that she is sad and has a bubbling personality. He is not to be aware that his father is dying at home. His wife feeds him, bathes him, massages him. He sleeps most of the time. His mother comes to visit and complains that he is away for so long and leaves again, being concerned about her son. Because of her hypertension her son insisted on non-disclosure. Then his wife finds him dead in his chair and people arrive at the house and darken the light from the windows with ash paste.

Background	Story of **non disclosure**, keeping up the status quo, avoiding the gossip, living with lies.
	Story of denying family members the reality of suffering and death by shielding them of access to their son and father
	Story of person being reduced to dying patient
	Story of **delayed grief,** as it cannot be communicated and shared.
Development	Wife going through process of living different lives and finding her husband less and less responsive to her care. Dealing with fear of exposure and loneliness in seeing him suffer. Her trauma shows where she still waves at the school bus after it is long gone, runs out of matches, burns the kettle; pursues a routine of care giving.
Climax	When her husband has died and she 'screamed his name in a whisper'
Ending	She fulfilled her task and now the community came in and took over

Both stories provide insight in the realities of dealing with consequences of HIV/AIDS where loved ones have become infected, develop AIDS and hide their realities from the outside world. Their surviving partners become disengaged from the surrounding cultural and societal norms and in order to survive and re-engage, they become untruthful which prompts them to secrecy and denial of responsibilities.

The next two stories tell of gender imbalance and high risk behaviour.

Dominant African Culture

Baba's gifts – culture through the eyes of a rural woman, the difficulties many women face in negotiating safer sexual practices. (Robson & Zondo 2004).

Table 3.7. ABDCE Outline for the story "Baba's Gifts". (Robson & Zondo 2004).

Action	Husband returns from the mines. Wife has been educated on condom use, concerned to find the right words that not make him angry. Convinced of importance, for the sake of her 3 children. Everything well prepared for his home coming. Meets him at the bus. Smiles as people are watching. He hands her chicken pieces and a box with his goods. He asks about his family's wellbeing. She starts talking, but doesn't come to the topic, as he is greeting his friends. He goes to his parents' home and she prepares the food. Father returns and gives presents to his children and bought her a blouse. His parents arrive and praise his wife's behaviour in his absence. She still contemplates when to talk. Remembers the AIDS education in the clinic and the straight-forward talk and demonstration on wooden penis by a nurse that wasn't even married. She had looked down, ashamed. In the evening, her husband is bathing, she gets nervous. He may become angry, or suspicious. He invites her into the bed. She takes a condom out of her clinic bag and asks him to use it, for the sake of the children. He laughs and ridicules the nurse and tells her to throw that nonsense away and she knows she must do what he instructs.
Background	Story of migrant labourers with families on the farm. Story of rural extended family life Story of gender imbalance in approaching a man about safer sex practice Story of integrity involved in community education and cultural applicability.
Development	The woman has made up her mind to approach her husband but cannot find the right moment and when eventually she does approach him, she makes her action depending on his response. Her responsibility was to speak to her husband, now that she has done so, it is for him to decide.
Climax	When she shows him the condom and waits for his response
Ending	Acceptance of the outcome as culture speaks louder.

Dominant African Culture

Mpumi's assignment. Constructions of masculinity based on sexual prowess and conquest have now become deadly. (Mahala 2004).

Table 3.8. ABDCE Outline for the story "Mpumi's Assignment". (Mahala 2004).

Action	Son observes his father and a friend talking, drinking and laughing. Reflects on churchgoing mother, him being proud of her singing voice. The men talk about hardships they conquered, fights they won and girls they admired in their youth. The story is told of a teenage girl whose boyfriend got replaced by men in cars. Men older and wealthier. Then she lost much of her beauty and prostituted at the local shebeen. The boy's father mentioned that now she has AIDS. The other man, a managing director, becomes really nervous and tells his friend that he had sex with this particular girl and his wife had found her earring, and he confessed to her but now would have to tell her who it was. She had been faithful to him and warned him about his 'bad ways'
Background	Story of proof of masculinity based on bravery and multiple partners

Story of culture where women tolerate their husbands having extra-marital affairs. Story of separate activities for men and women. The men are unfaithful, drink, smoke and share their stories, the women are faithful, go to church and do the housework

Story of children listening to their fathers stories and are expected to praise their fathers and follow in their footsteps.

Story that church is for women and small children and not for men and older boys. |
Development	Men sit and talk about bravery and being with girls and then realise their risk and the same stories become a threat when they realise what's all at stake.
Climax	Friend saying: in the past a man achieved greatness by having sex with more girls than his fellow men, what we have to realise is that things are different now, and he cried
Ending	Open ending, creating expectancy that friend will check his HIV-status and disclose to his wife. The son witnessing the change in conversation.

Both stories make mention of the voices of society appraising male dominance and supporting promiscuity. The cultural norm is of having affairs and then 'owning a wife' who is expected to submit to the sexual demands of her husband. Both stories confront this reality with the threat of HIV infection and the choices that better informed partners have, in breaking this multigenerational cycle of male dominance and risk taking behaviour.

The last two stories tell of living a life embedded in tradition and mobilizing the community to provide education

Community mobilization

Siphiwe Hlophe   (Nolen 2007).

Table 3.9. ABDCE Outline for the story "Siphiwe Hlophe". (Nolen 2007).

Action	Siphiwe Hlophe' father had 3 wives and 25 children. Her mother was sent away, her stepmother passed away and she grew up with 24 siblings. She herself asked at the office of 'save the children' for shoes and received sponsorship for boarding school and then was told to study agriculture. She married had 3 children and was told by mother-in-law to take contraceptives. Clinic required permission from husband. They were not married, so she eventually told a lie and made her sister sign. Siphiwe became an outreach worker and left her family to study further in Agriculture. She won a scholarship to study oversees and then tested HIV positive. Her husband accused her of having affairs, and moved out. Her sister had died of AIDS five years before and she helped nurse her. News spread about her status and people in her work projects avoided her. Siphiwe started Swapol, an organisation for support and orphan and community care. She then became part of the government body coordinating prevention and care projects. AIDS became her job. She travels the country, helping communities plant gardens, making provisions for child headed households, empowering women. Her own husband returned home, apologised and confessed that he had infected her. His health was not good, he lost his job and a former girlfriend died of an AIDS-related illness.

Background	Authentic story of polygamy. More wives means more wealth and many daughters provide a great cattle. Story of upbringing with stepmother, harsh treatment and child labour Story of resilience, a vibrant personality and perseverance Story of bureaucracy in government institutions, not allowing for best health choices Story of lobola allowing for male dominance, and acceptance of promiscuity within marriage Story of clan and community responsibility and importance of networking Story of love and family loyalty Story of dismay about authority and life style of the king of Swaziland, and consequences related to foreign funding (38.6 % of the population is HIV positive)
Development	The life world of a woman who developed her skills and resources to support her country in finding ways to combat living with HIV. She remains subject to her king, her clan and her husband, but within these constraints has earned much respect and support.
Climax	what is at stake is her health and her hope that she would not get sick soon, so that she can work
Ending	Siphiwe carrying on with her family and her work life as long as she can

Community mobilization

10. Samkelisiwe Mkhwanazi (Mkhwanazi 2001).

Table 3.10. ABDCE Outline for the story "Samkelisiwe Mkhwanazi". (Mkhwanazani 2001).

Action	59 year old woman, who from her pension supports daughter with multi drug resistant TB, daughter with AIDS, two other unemployed children, and seven grand children. Then her daughter with AIDS passes away. Her daughter with TB was in hospital diagnosed with TB and HIV and went to a traditional healer and stayed there for three months. She was treated with herbs, water and herbal medicine. This did not seem to have any effect. Daughter decided to disclose her status to the community in order to help educate others.
Background	Authentic story of poverty and whole families living off one pension Story of drug resistance because of defaulting, here the combined diagnosis of TB and HIV infection made her daughter decide to rather go to a traditional healer. Story of reversed care giving. Mother would be cared for by her children and here she becomes the primary care giver and her children are ill and die. Story of struggle to care for her children and grand children so that they will live.
Development	Care provision based on motherly love.
Climax	Reciprocity of love and respect. Mother provides care, daughter provides education.
Ending	Provision of palliative care until her daughter dies

The above mentioned stories describe the reality of starting community based initiatives and addressing the real issues, whilst going through grief and living amidst ignorance and denial of the reality of HIV/AIDS. Hence there is need for community education and project development.

3.5 Identify and describe specific discourses/traditions in families, communities and within the churches which inform their perceptions and influence behaviour related to HIV/AIDS

The researcher here links the life world of families living with HIV/AIDS, and the response of the churches as described throughout this Chapter, to the themes as derived from the descriptions and in-context experiences of the described narratives. The researcher uses literature as relevant to the interpretation of the themes.

The following themes were derived from the descriptions and in-context experiences of the described narratives. The researcher points to areas of attention relevant for pastoral family therapeutic counselling, which will be further developed into training material.

1. **Poverty and HIV**

HIV/AIDS is a poverty related condition. Impoverished circumstances make it hard to maintain a healthy lifestyle and having basic needs met. Burkey (1998) added the basic needs of the community, e.g. language, culture, spiritual support, a system of security, health and recreation. Haddad (2001) mentioned the church in the community as a resourceful institution, but at the same time not aiming for transformation, and impoverished women themselves becoming a resource for development. Louw (2004) developed a hermeneutic model for counselling in poverty. The emphasis is on the 'space' between the affective polarities of distance and proximity and the normative polarities of vocation and discipline. The position of the counsellor as apathetic, frustrated or relating unconditional love and working towards development is discussed. Van Niekerk (2005) mentioned prostitution and lack of basic services as being side effects of poverty.

2. **Sex & Gender**

Women are vulnerable to HIV/AIDS because of biological disposition and socio-cultural factors, e.g. the payment of *lobola* creates the perception of 'ownership'. There is a need for education on sexuality, sexual identity, and homosexuality within the churches. Attention needs to be given to responsible fatherhood, constructs of masculinity and negotiating safer sex practices. Denis (2003) mentioned the discourse of sex "as a force that needs to be domesticated, contained and moralised" compared to understanding sexuality as "a reality determined by social, economic and cultural factors" (Denis 2003:30). In many churches speaking about sexuality is pastorally and culturally insensitive. Therefore it is also difficult to speak about HIV/AIDS (Haddad 2006). Several organisations made information about sexuality available to churches, e.g. Family Health International.

3. **Stigma & Denial**

Stigma and negative attitudes towards people increases discrimination. Stigma prevents people to obtain access to resources, getting tested, and seeking support from friends and family. The roots of stigma lay in the 'deadliness' of HIV/AIDS and the fear this has caused in communities. Deacon et al (2005) mention that people are socialised to self-stigmatisation by internalising stereotypes of HIV/AIDS prior to HIV infection. Contextual and social stigma are relating to communal attitudes and norms (Paterson 2005). Churches have been seen as defenders and promoters of moral and social norms, which can then result in personal and structural denial of reality or stigmatisation within the church.

4. **Bereavement & Trauma**

Each of the above described narratives was bearing witness to suffering and losses. There was purposeful grief, postponed grief, isolated grief, the complexity of multiple losses, anticipated grief and denial of the losses. The researcher has become aware that understanding the process and complications of mourning are inherent to HIV/AIDS counselling and need a prominent place in the training programme (Worden 2005).

5. **Abuse & Violence**

Domestic violence, substance abuse and rape put people at high risk for contracting HIV infection. Oppressed women have little control over their sexual practice (Haddad 2002). In African traditional communities, women were expected to accept wife-beating and also in churches, abused women were often supported to remain in violent relationships (Nasimiyu-Wasike 2000). Oppressors' stories influence the stories abused men and women tell about themselves. These stories are often reinforced by 'messages' from the social surroundings, e.g. 'she is a bad girl'.
The contextual and narrative family therapeutic skills training will be aimed at e.g. identifying patterns of abuse and creating alternative 'preferred stories'

6. **Church & Theology**

People living with HIV/AIDS are negatively affected by churches when the theology of sin and judgement results in punishment through communal rejection and stigmatization. They can also be negatively affected by churches when a more compassionate theology tells them that what happened in their lives, e.g. losing a child to AIDS, which is existential guilt, doesn't matter, as we are all vulnerable and coping with losses. Louw (2006) argues that there needs to be a theology of resurrection hope, that "assesses people from the viewpoint of a constructive and realistic affirmation and validation of their identity and dignity" Living with HIV/AIDS would need to be defined in terms of realistic hope (Louw 2006: 104). The researcher sees the need to discuss the theological discourses of sin, retribution and hope as well as the role of the church in prevention, care, counselling and its leadership structure, with the course participants in the training model.

7. **Health Care**

Areas of attention relevant for pastoral family therapeutic counselling, are dealing with chronic illness and access to treatment, hospice and palliative care. Churches, as FBO's become part of the service provision for VCT and ART and initiators of systemic

home based care in communities. Families, through the churches, provide supportive care to each other (Magezi & Louw 2006). Many people consult traditional healers before coming to the clinic and take their council related to the understanding of HIV/AIDS. Multiple deaths in families are understood to occur because of upsetting the ancestors or being bewitched (Benn 2002). In the African Indigenous churches, prayer is not resulting in healing, therefore many disappointed pastors are doubting their ministry (Haddad 2006).

This aspect too will be addressed in the training model where church leaders are provided with relevant information and counselling skills related to chronic illness, palliative care and death. They also need to receive bereavement and trauma counselling skills and theological perspectives on the ministry of healing.

3.5.8   Dominant African Culture

African religious leaders have been identified as trusted and respected members of their communities. To eradicate the stigma and discrimination in their communities, they are challenged to help transform their churches and become small educators and spokespersons in order to provide information and secure community based services. Healthy family life and community growth are at stake, and therefore an appeal has been done to the practice of compassion, leadership and moral responsibility (UNICEF 2003). The training model would seek to encompass concise and accurate information for community leaders on issues of HIV/AIDS and community service provision.

Areas of attention relevant for pastoral family therapeutic counselling are family values, rites, lobola, polygamy, funerals, enculturation, and the position of men, women and children in the home and the church. African communal care within families can create expectations that may at times be hard to meet for its members. HIV positive couples are expected to produce offspring and heirs. Members of the family that are earning an income are expected to take financial responsibility for others. After a death, family property is shared, sometimes without taking children into account. Family members

often conform to the norms and traditions because of mutual respect, dignity and therefore protection within the family system (Magezi & Louw 2006). The narrative and contextual approaches in family counselling training specifically relate to cultural constructs and issues of family entitlements and loyalties. Therefore these modalities are considered in the training model.

3.5.9 Community Mobilisation

Guyer (2006) distinguished between community mobilization and community organizing efforts. The traditional discourse of leaders who are: 'having all the answers', 'remaining firmly in control' and 'decide on any action', would need to be de-constructed and leaders to become community facilitators and organizers. They would help various parts of the community to identify their common interests and work together to achieve those. Special interest groups would need more organizing, e.g. health issues for street children (Guyer 2006).

 Areas of attention relevant for pastoral family education and therapeutic counselling are open communication, skills sharing, collective action, community care provision, resource development and collaboration. The extended families and concerned community members also form informal safety nets for families living with HIV/AIDS (Foster 2005). The researcher's training model would tap into these formal and informal community safety nets.

3.5.10 Communication in Families

Brandt (2005) mentioned resilience, vulnerability and wellbeing as multi-demensional processes. His research with mothers and women care givers on ART showed that the themes involved in the communication about living with HIV are about risks and benefits of disclosure, concerns regarding the children, certain household dynamics and stressors, as staying with mentally unwell relatives, issues of employment and financial dependence. Brandt (2005) commented that the role of men in the homes was

multifaceted. They were not just perceived as being absent or doing harm, but valued as contributing to the life world of the family and grieving the losses in the home and extended families.

Adam and Sears (1996) mentioned the reality of unsupportive families, expressed in negative messages of family 'quarantine', family rejection and the unspoken agreement of same-sex relationships remaining unacknowledged. They also make mention of limited communication styles within families, whereby disclosure of the HIV status may result in the topic being treated in a secretive manner (Adams & Sears 1996).

Areas of attention relevant for pastoral family education and therapeutic counselling that target improved communication include marriage preparation, gender roles, couple relationships, family enrichment, parenting, healthy life style , adherence support and counselling regarding financial management and issues of employment, e.g. skills development.

3.6 Describe the conversations of several disciplines, e.g. theology, social work, family therapy, regarding their paradigms and approaches to the problems that families living with HIV/AIDS are dealing with.

The intention is to integrate the various stories of understanding into a coherent whole that adequately accommodates all stories.

The researcher first set out to describe a hermeneutic, systemic and social constructionist approach to the fields of theology, social work and family therapy. The purpose of this exercise is to design training materials that are relevant for church leaders and lay counsellors in their provision of counselling to families with HIV/AIDS.

3.6.1 <u>Post modern times</u>

Ganzevoort described postmodernism as an attitude of individuals and groups, whereby they deny the option of an integrating life story. The idea of an overarching story of meaning is therefore lost. What remains are fragments that are perceived as meaningful. Each person chooses his or her own story to live by. Criteria on viewpoints and action can only be found within the person who makes that decision. Gansevoort explained that in dealing with fragmentation, even a splinter of faith in the lives of people we meet, is sufficient to start walking a journey, realising that for many people the fragments of life cannot be integrated into a coherent story (Ganzevoort 2004). In this study, the researcher would adhere to above mentions realities and train the church leaders in family counselling skills that show respect for the integrity and vulnerability of families going through a process of truth finding, in which they are guided to find these unique outcomes of inner strength and resilience.

3.6.2 <u>Practical hermeneutic narrative theology</u>

Heitink (1993) defined practical theology as an empirical orientated hermeneutical theological theory about the active role of the Christian faith in the practice of our modern society. Heiting described practical theology as a communicative and action oriented science. Paradigm and methodology are to be found within the realm of the human sciences.

He discussed the following perspectives in practical theology:

1. The hermeneutic perspective: cycle of preconception- observation/experience- interpretation/discourse-meaning and action. The practice is about understanding.
2. The empirical perspective: cycle of observation- induction/ hypothesis - deduction/prediction-practice-evaluation. The practice is about explanation.
3. The strategic perspective: cycle of problem definition -diagnosis -plan - intervention -evaluation. The practice is about change.

Heitink based this perspective of hermeneutic-communicative practice on the work of the philosopher Ricoeur. The paradigm is the interpretation of a text. Text can be understood as a written or oral script, but also as a social institution, art and monuments (Demasure & Muller 2006). The text is explained with the use of methodology, which undergoes a dialectical movement of understanding and explanation. The dialectical movement creates potential for change. The object of this exercise is meaningful action. The regulative circle is constantly informed by the other two circles (see picture).

Figure 3.1 The methodology of practical theology. Heitink (1993). Translated from Dutch
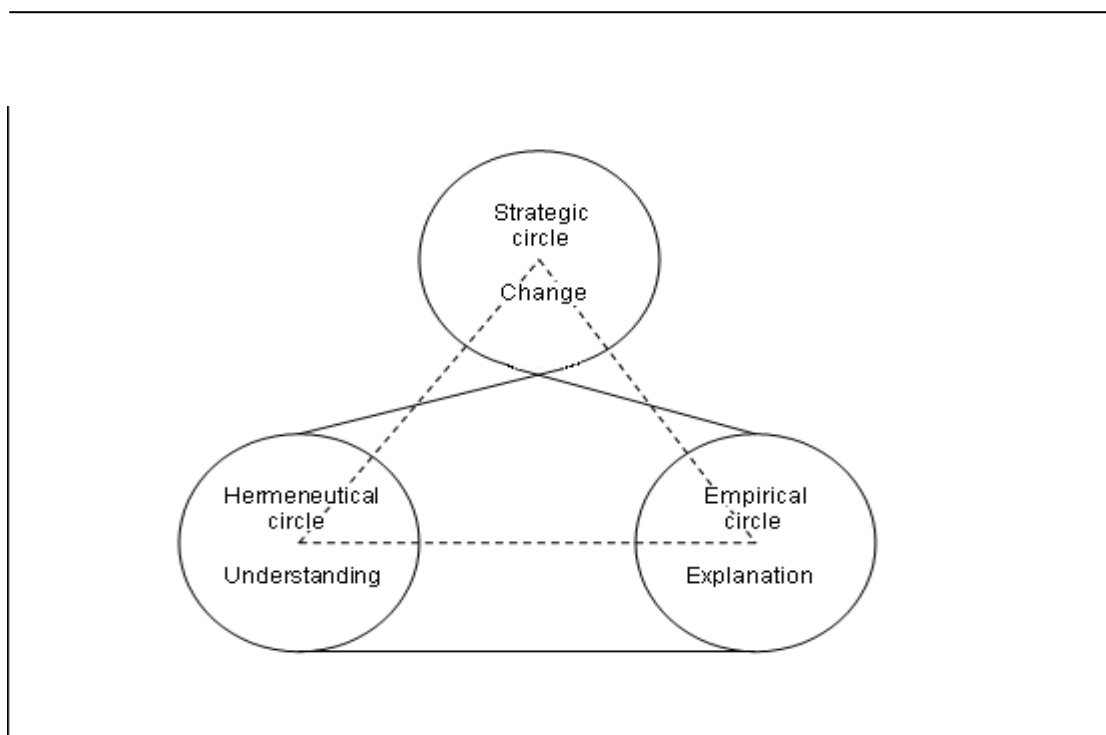
Ricoeur's terminology for the hermeneutic spiral are prefiguration, configuration, and refiguration. The person's world of pre-conceptions meets with the textual world and the developed understanding leads to new perceptions and practice. The circular process continues until satisfactory interpretations have been made. For the purposes of this study the methodology of practical theology as described by Heiting, will do justice to the multifaceted problem situations in which HIV positive families may find themselves, as church leaders will require multiple skills in assisting families to gain knowledge and understanding in dealing comprehensively with these problems.

Important in this context is the philosopher Gadamer's notion of the merge of the 'horizon' of the textual world and the person's world. The distance between the two worlds is seen and can lead to a 'disclosure', an opening to refiguration. The vantage point is important for the extent of vision and changed practice (Gadamer 1985).

Important for the development of a training model for church leaders and lay counsellors is the critical perspective in the relationship between the formation of theory and practice. The historical and contextual voices and factors are heard and analysed. The result is critically informed practice. Also important is the evaluative character of the empirical circle, which enables testing theories that have been developed.

Heitink distinguished the following three action fields in practical theology :

1. **The life of the individual person**, who gives meaning to his life from a religious perspective. For many young people, their faith is no more than a thought construction, associated with church and home and no longer as part of work, school and friends. Differentiation in society would lead to fragmentation of the life experience. Faith development would need to focus on asking and discerning instead of stating and knowing. The practical approach in theology would look for a 'lived view of self', a reference to help people decide how to conduct themselves. This normative view of self is presented in story-telling, or tradition. Heiting mentions that the reflected image as presented in practical theological anthropology is subject to the self image of the individual person. This subjectivity is biographical and relational. Faith development and gender identity, as discussed earlier (Fowler 1987) and healthy religious experience belong to this action field.

2. **The church as community of believers.** The action field is about a systematic approach to being church. The church's identity, integration, organisation and governance. The social identity of the church as in

114

fellowship (*koinonia*) is important as its normative and critical reference. It encompasses liturgy, *diakonia* and martyrdom. Haiting discusses pluralism, locality and the autonomy of the church.

3. **Christian presentation in society**. This relates to the relationship between church and state and the role of Christianity outside of the church. It also relates to the role of community faith based organisations as well as to the role of individual Christians in society. Churches are to be partaking in community policy making forums, and being involved in discussions on moral and medical ethics. Noordstokke (2000) refers to diakonia as attending to minorities who are affected by prejudice and exclusion. He mentions the inclusivity and unmasking of injustice as modelled by Jesus in the Bible stories. Reference can be made to people living with HIV/AIDS and misplaced immigrants.

This is relevant to the study because church leaders in their counselling practice meet with all 3 action fields, as they are relating to individual persons who represent families who are part of a (church) community within a specific cultural setting. Further, the church leader is concerned with the hermeneutic-communicative praxis in building a community of believers. The richness and complexity of these action fields requires triangulation with other fields and sources, like social science, in finding constructive ways of dealing with psycho-social problems as presented in society. Van der Ven (1998) defined hermeneutic-communicative practice as the interpretation of text, written and oral, and their communication, both verbal and non-verbal. He emphasised that the practice related to the basic functions of the church, namely '*kerygma*', '*leitourgia*', '*koinonia*' and '*diakonia*' cannot only be described as hermeneutic-communicative practice. All areas of practice are dependent on other resources and technology. At the same time he recognised the interpretation and communication of texts as the core function of all meaningful church practice and emphasised the critical interpretation and communication about oppressive societal factors. These factors can be economic, political, cultural and spiritual.

Within the practice of critical hermeneutic communication Van der Ven referred to Habermas' three basic linquistic modes of communication, which are considered necessary to note in this study because the life world of people living with HIV/AIDS and the personal narratives and praxis of the church leaders need to be addressed in a holistic manner. Futher, the family counselling practice needs to be discussed in relation to the rightness of its action, the truth of the faith in which it is rooted and the authenticity of the practicing counsellors.

(1) The objective mode, is concerned with truth contained in described situations.
(2) The social mode, is concerned with the rightness of described attitudes and behaviours and therefore the formulation of values, norms and conventions.
(3) The subjective mode, is concerned with the authenticy of what has been arrived on and makes use of one's own expression of feelings, images and beliefs.

Within the training model, praxis coordination takes place of the hermeneutic communicative practice as participants reconstruct, reflect on and reinterpret their own praxis and communicate their choices and findings to each other. The trainees can then establish and develop new understanding of their praxis and set out to find consensus as a group.

Van der Ven (1998) mentioned 'intergenerative communication' as a form of hermeneutic practice where reflections from the past and contemporary reflections from the present are presented as a dialogue of relationships. This critical paradigm will create space for pluralism and conflicts of interpretation, validation of new interpretations and through revelation of the meaning of traditional texts, bring out their transformative power.

Ganzevoort (2004) developed a model of practical ministry, based on Browning's five dimensions of moral reasoning, e.g. the visional level, the obligational level, the social-environmental level, the rule-role level, and the tendency-need level (Browning 1991).

The model emphasised the role of the church leader and is considered useful to the present study because the church leaders and lay counsellors participating in the training model may interpret their position in their churches and in their counselling

practice differently and can in the training programme be taken through the above mentioned dimensions of moral reasoning. This will help them gain a clearer perspective on their role in the churches, the way their ministry is perceived, the interdisciplinary discussions about being Church in community, and the position and response of their Churches related to social and environmental problems.

The moral reasoning steps of the model are presented hereunder:

1. **Visional level**: the identity of the minister is depending on various discourses, as his self-understanding is shaped by a tradition determined by stories and metaphors. The concept of **ordination** can be understood as stemming from religious tradition, or as social and religious legitimization, in which power dynamics become important. For the congregation, ordination may mean expectancies or putting him on a pedestal. Practical theological discourse needs to overcome the barriers in this dialogue. The concept of **profession** stems from the organisational realm. Professionalism promises well-defined standards and aims, but also the employ of strategies to gain a position of power. For the congregation professionalism may mean limited availability or expectation of quality work. Systemic theological discourse poses questions regarding the action of God as working behind and through the minister. The concept of **personal charisma** would often be expressed in and through ordination and profession.

2. **Obligational level**. This level deals with ethical demands, and general moral principles. What is the minister's task, direction, mission? What is the core business of the minister, e.g. to represent God, or to serve the people? Is it management, education, counselling? The discourse chosen in the visional level will determine the discussion on normative criteria for this obligational level, which may all lead to a different description of the task and mission of the minister.

The task of the minister is truly theory-laden and therefore normativity-laden. This praxis is part of the first order discourse (within the congregation) that practical theology

investigates and brings into dialogue with second order discourses of theological and social-scientific disciplines.

3. **The tendency-need level** of practical reasoning investigates the hierarchy of pre-moral needs and tendencies, and therefore is normatively defined. This is apparent in discussions on condom use as discussed in the church. They all circle around the question of the relative weight of conflicting needs and tendencies. The important issue for practical theological investigations here is the awareness that first order discourse on these topics is informed by second order discourses of e.g., sociology and theology. Many debates about condom use are framed in the conflict between 'young people have sexual partners' and 'the Bible says so'. These first order understandings portray different normative criteria grounded in naive anthropologies or readings of Scripture. For the practical theologian the task is to clarify and perhaps challenge these understandings. Obviously, the practical theologian's personal opinion will influence this task. Empirical investigation of the normative criteria will include these first order understandings, the opinion of the practical theologian himself or herself, and the second order discourses of (in this case) biblical theology and sexology. This dialogue will display conflicting hierarchies of moral principles and are important to include in the training model as discussed in the earlier part of this chapter.

4. **Environmental-social level** the social-structural and ecological constraints of a particular congregation and ministry, e.g. impoverished communities. This level requires intradisciplinary integration of social science and practical theology. In the training model, the church leaders will gain skills in establishing a community profile and needs assessment in order to intelligently refer families for further counselling and psycho-social support. Church leaders are sensitized to ecological problems and prompted to recognize them as intrinsic to their core ministry.

5. **The rule-role level**. The most concrete level of actual guidelines for practices and behaviours, together with the institutional structures of a church or a non government organisation. Ganzevoort welcomes at this stage the inter-disciplinary integration of social science and theology, as to be able to understand the possibilities and limits of the therapeutic models we are to develop. He realises that social workers too are concerned with vision and obligation, just as much as theologians have to engage in tendency-need, environmental-social, and rule-role levels (Ganzevoort 2004).

For the development of training materials about certain discourses in the church, e.g. the discourse of sexuality, the researcher believes that an interdisciplinary dialogue would be paramount. The Model as designed by Gansevoort provides insight in the dynamics both in the 'identity formation' of the minister as well as his or her role in society. In the African Initiated churches the moral obligation towards the ancestral world would for many of the churches play an important role.

3.6.3 <u>Narrative practical theology and pastoral care</u>

Demasure and Muller (2006) mention a paradigm shift in pastoral care in the 1980's from the therapeutic model to the hermeneutic model. In the therapeutic model the counsellor is the expert, who knows about different types of problems, the cause of problems and solutions to the problems. (S)he makes use of an explanatory model. The hermeneutic model is dialogical and metaphorical in that it seeks understanding and interpretation of meaning in the meeting between God, the counsellor and client. A hermeneutical model validates metaphorical or symbolic (non-literal, figurative) interpretations of the narrative. Being described as 'heuristics', it becomes a way of discovering in order to comprehend and interpret. The counsellor would take the role of facilitator and interpreter of meanings (Louw 2004). Louw (2004) mentioned that this approach can only be successful when there is a shared perspective of faith.

Bons-Storm (1989) described the role of the counsellor as in dialogue with the person's field of experience and the field of the Word of God. The counsellor positions or finds him/herself in the X, the cross roads between the 2 circles

Figure 3.2. Hermeneutical Adventure. Search for points of contact between the human narrative and the narrative of God. Bons-Storm (1989).

Man's field of experience

The Christian tradition,
the Word of God

First
hermeneutical
process

Second
hermeneutical
process

X = the pastor in
dialogue with the
other
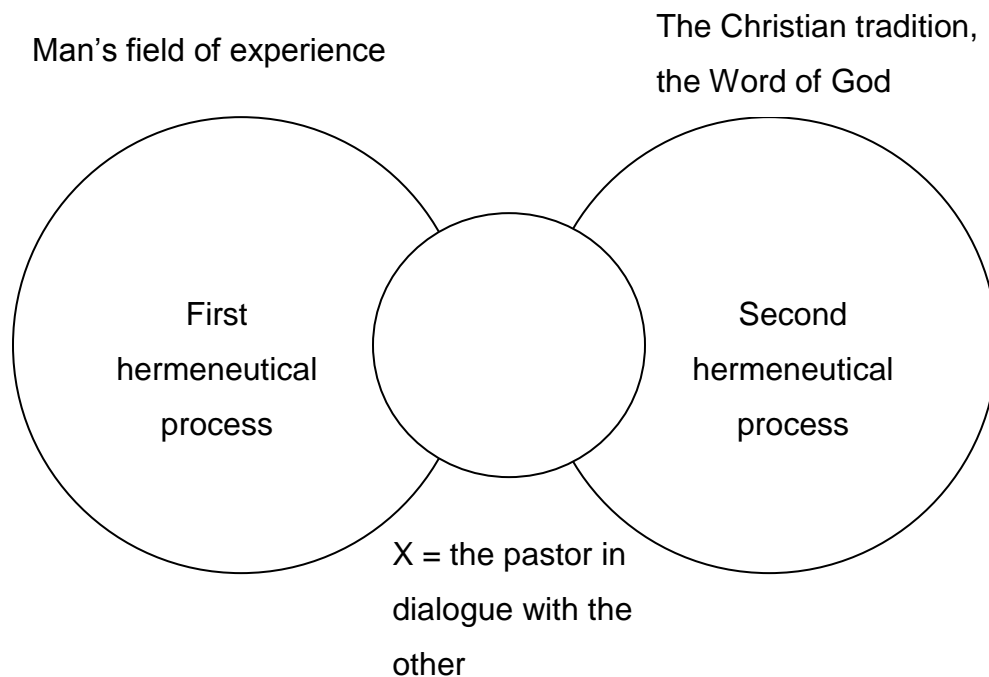
The counsellor represents a specific representation of God, related to the presented story. According to Bons-Storm (1998), the image of God that the counsellor would introduce, is culturally constructed through the counsellor's theology and anthropology. The choice of metaphor is also related to the person's understanding of what the metaphor represents. Stroup (1991) refers to the collision between a person's narrative of identity and the narratives of the Christian community. Terrien (1985) mentioned the example of 'the Father' metaphor, which can have negative connotations, for example with sexually or physically abused people who seek counselling. Patriarchal domination also misrepresents the Biblical perspective on God as father. The Hebrew word that Jesus choose for Father, can be translated as tender care, and responsibility for the

wellbeing of the family (Terrien 1985). Texts can also be read through the lenses of gender constructions, and gender empowerment. Dube refers to the Bible story of Mark 5:21-43 and points out certain gender disparities as described in the story, a nameless, non-professional women in need of healing, exploited by health professionals. Jesus relinquished His power to her, told her that her faith healed her, called her 'daughter' and released her from isolation (Dube 2003).

The hermeneutic model as based on Ricoeur, relates to people's actions as being pre-narrative, and providing the material for the construction of stories (configuration). He requires the reader (counsellor) to read with suspicion and become critically aware when projecting their own wishes and constructs into texts (person's stories). When that happens, it is important for the counsellor to 'cleanse' the story from these ... Therefore to listen in openness to symbol and narrative and allow creative events and find its true message (Thiselton 1992). The hermeneutic model is relevant to this study, where it seeks to understand and interpret the life world of HIV positive people, through dialogue and metaphorical interpretation of meaning. This is a shared process, where the counsellor's need to become aware of their own process of 'truth finding' and the training model needs to provide opportunity for the pastoral family counsellors to prayerfully work through their own life stories and therefore not to project their own 'truth' into the counselling process. Frei (1974) emphasised the importance of a 'literal' reading of the text (person's story), in terms that the meaning of the narrative resides in the narrative itself. He refers to the pre-modern area when truth and meaning were identical and literal and figurative reading supplemented each other. The meaning is identical with the description of the story. The characters, social context, circumstances, incidents and themes in the story, are all interdependent. The reader (counsellor) would ask a 'formal question', which Frei refers to as a content-less question, so that the story fills in the content and reveals its own meaning. This meaning is then unique and mysterious, as its affirmation lies within the story (Frei 1974).

Willows and Swinton (2000) described contextually and situationally sensitive pastoral practice as being precise, particular and distinct. Careful communication through careful observation and understanding is encouraged. Modesty in claims and assertions at the

same time provide release to particular individuals and communities (Willows & Swinton 2000).

Ganzevoort (2004) mentioned that in a social constructionist framework, practical theology is described as a multi conversational discipline between theology, other disciplines, the church and society. Discourses then determine how observations are understood, what needs to be achieved and how each conversation has its own empirical and normative dimensions, e.g. truth claims and ethical standards. He uses the notion of first and second order discourse, relating to knowledge of self, world and God, being socially constructed and distinguishes between ordinary religious language and action and the academic discussion of this language. Van der Ven adds that the explanation and understanding of praxis, as further developed in models and strategies, and its inherent normative statements are in no way the authoritative domain of theologians (Ganzevoort 2004).

The researcher believes that the multiple conversations between practical theology and social science provides a rich description of action, history and development of praxis for the pastoral family counsellors. This becomes a resource within the counselling relationship between God, the pastoral family counsellor and the counsellee.

3.6.4 Theological practice related to families living with HIV/AIDS

Cochrane (2006) pointed out that HIV/AIDS presents a socially comprehensive health challenge, which needs response at all levels of society. He distinguished between churches, faith based organisations and ecclesial practice, the life of Christian communities. He described the Masangane project, a faith based initiative, as a comprehensive approach to health as the leadership connected their understanding of the real systemic conditions and barriers to health, namely inequality and deprivation, to an understanding of health that has its base in justice and therefore provides public community health. They started providing access to services by making these available, affordable and acceptable. "An intense focus on the totality of HIV/AIDS demands that

attention be paid to the transformation of the conditions that exacerbate it" (Cochrane 2006:22).

The researcher decided to mention the above model because of its comprehensive and structural approach to the real needs and the work to be done. This project is embedded in collective research that was undertaken by several universities (the African Religious Health Assets Programme). For the training programme the Masagane project can be studied, critiqued and utilized as a model for case study and project assessment. Churches that are going to provide pastoral family counselling, may already host and partake in an HIV/AIDS site and ART adherence programme. These Churches are often linked to income generating initiatives, to which HIV positive persons can be referred.

3.6.5 Hermeneutics in Social work

In this section the researcher described a hermeneutic, systemic and a social constructionist approach to the social work profession. The role of social work related to families with HIV/AIDS is approached from different vantage points, e.g. challenges of parenting for families living with HIV/AIDS.

Phases two and three of the Intervention Research Model are herein followed viz. the information gathering and synthesis, as well as the specification and definition of dominant discourses in families with HIV/AIDS which need to be changed.

Family therapy is embedded in social work practice and therefore the researcher thought it important to discuss both disciplines.

Many Bible Colleges and Theological institutions require their students to be involved in community practice. The field of social work and family therapy can render a great service to these students by providing them with the necessary information and practice skills.

Figure 3.3. Hermeneutic circle Dummer et al 2004.

P₂ **P₁** **P**   **U** **U₁** **U₂**

P = pre-understanding

U = understanding

P_1 = advanced pre-understanding...

U_1 = advanced understanding...
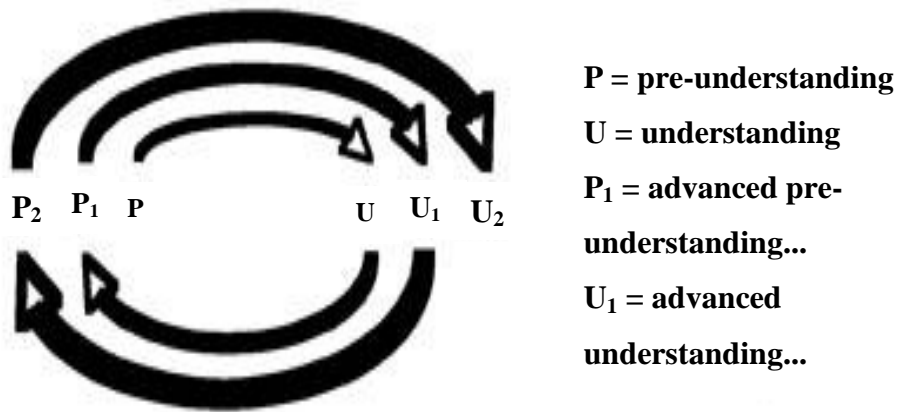
Within the hermeneutic circle, part and whole, pre-knowledge and learning about the person, and theory and practice, are all within a reciprocal enlightenment relation. Thus the experienced interpreter (e.g., the social worker) comes to a real and fundamental understanding of a situation or a person. The social work profession also embraces a post-modern hermeneutic model, in which the social worker becomes aware of pre-conceived ideas about the life world of clients and their problem situations. The methodology that is followed would address subjectivity and reduce the risk of transference of 'own experience' from the counsellor. The above described hermeneutic circle can also relate to problem situations that are structural in nature. The social worker would engage in a critical reflection of the role of societal structures, that are supporting the current problems and actively engage with the client in appropriate action. (Dummer et al, 2004).

Figure 3.4. Risk Assessment Dummer et al 2004
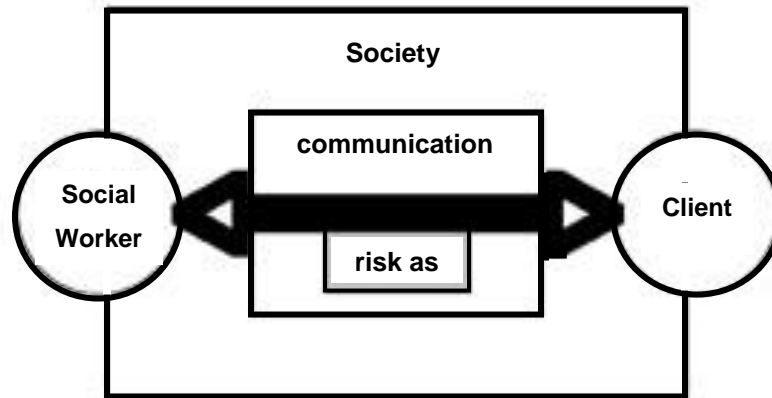
Thiersch (2004) positions hermeneutic ideas within a critical paradigm that exposes the contradictions of our society. The client's "everyday world" is between "system" and "everyday life," and therefore the duty of the social worker is to draw the attention of the clients to their problems, and create awareness of the social causes thereof. The social worker supports the connection between individual help and community care, political action and empowerment processes. The social worker, therefore, facilitates a communicative and reflective process, whereby the client becomes more conscious of negative trends. "Within this view risk is not something to avoid, but to take, and communicated, as otherwise there would be no social progress or social change" (Thiersch in Dummer et al 2004:3).

The hermeneutical, and critical traditions are losing credibility in the western world, as possible risk taking within helping processes is no more acceptable. Because of legitimacy, effectiveness and transparency of social work, more rational theories like the systemic theory are gaining importance, with clear criteria for its procedures and interventions, including possible risks and dangers. However, the authors argue that if social workers are only aware of their social function and don't dare to take risk at all,

they will no longer be able to stand up to their ethical and critical commitment to support the individual not only for, but also against society (Dummer et al 2006).

Bodor described philosophical hermeneutics as a worldview "that grants value to the contexts and understandings of place, history, experiences, voices and text" (Bodor 2006:1). Bodor emphasized the hermeneutical historical viewpoint that the human sciences require subjective understanding of experience, which is an ongoing authoritive process. The purpose of this process is to challenge and deconstruct authoritative assumptions that we hold of understanding our world. Bodor valued this approach in social work with remote and rural communities, because it speaks to beliefs, values, context and the interpretation of our own life world. In this study, research participants reflect on their families of origin as well as the communities that their families belong to. Families living with HIV are possibly families that are living in impoverished circumstances, deprived of health services, belonging to a minority population group and opposed because of stigma and discrimination related to their HIV status. Challenging and deconstructing authoritative assumptions may take place in an individual or familial counseling session as well in community social action that is undertaken on behalf of clients in an advocacy capacity.

"Hermeneutics has to do with a theoretical attitude towards the practice of interpretation, the interpretation of texts, but also in relation to the experiences interpreted in them and in our communicatively unfolded orientations in the world" (Gadamer 1983:112). The hermeneutic process entails a listening to and a deep exploration of the stories from infected and affected people and a listening to the relational, contextual and historical voices behind the stories. This process of 'making sense of our world' is described by Gadamer as finding the underlying questions to the statements that we make (Gadamer 1983). In the study, the pastoral family counsellors are encouraged to enter this process of making sense of the life world of people living with HIV/AIDS and relate their practical theological understanding with the support of interpretation text and experiences from the field of social work.

This dialectical process of understanding and interpretation, by asking genuine questions, is experienced within the hermeneutic circle through the act of dialogue. The result is the construction of meanings. Within this process, we cannot 'bracket' our own thoughts and beliefs and be neutral. We need to acknowledge our life world and fore-knowledge and become aware of prejudices, our situatedness in history and time (Gadamer 1983). Hence, for the study the participants are encouraged to dialogue and construct meaning as a group, related to the life world of their current families and families of origin.

In this process, our historical consciousness will be changing, as we understand our traditions differently. Gadamer mentions the "I-Thou" relationship, where we open ourselves to the other and learn what we do not know. The position of not having a 'truth claim' opens to a merging of different vantage points. Gadamer described understanding and interpretation as the fusion of these vantage points, a fusion of horizons, a genuinely reciprocal process (Gadamer 1995).

Bodor adds the concepts of reflexivity and rigour to the practice of hermeneutics. Reflexivity means that the social worker reflects on the influence of background pre-understanding, value positions, experiences and narrative that shape the interpretive process. Rigour relates to trustworthiness and legitimacy. A value orientated approach, containing pre-understanding, originating in the historical context of social worker and client brings understanding, meaning and makes us into real people, who open their horizons to others and may have to change as a consequence of hearing something new and learning about ourselves.

In our practice with HIV positive families, the hermeneutic approach may make us aware that the complexity of life doesn't warrant to produce a specific, single explanation for life circumstances (Gadamer 1995).

The trustworthiness is experienced within the hermeneutic cycle, and means an integration of differences, multiple perspectives, within the context of the whole. Constructivist hermeneutics relies on language to communicate meaning and

understanding. This requires a hermeneutics of trust. At community level, it requires us to live in connection with the history and locally created understanding and the intertwining of the co-created realities (Bodor 2006). In the present study, the integration of differences and multiple perspectives are an outcome of the painstaking work of finding understanding, reflection and more understanding, which happens between pastoral family counsellors, counsellors and families as well as in the interaction with communities.

3.6.6   A systemic approach to social work practice

Burk and Cooper (2007) affirm the need to defend and sustain complexity and not to measure social work practice in simplified ways. They suggest to bring multiple perspectives to bear on social work practice, fitting a systemic theoretical framework and practice, e.g. a dialogue between systemic and psychoanalytic approaches, applying systemic and psychoanalytic ideas of how societal context influences inner reality and relationships between people. This means an exploration of contexts, both personal and professional and informing each position. Social constructionist ideas and narrative concepts, e.g. self reflectivity and relational reflectivity have informed and challenged both positions to stay open to new processes. Also in the supervisory relationship, a reflective space is created for listening to alternative stories and noticing different processes. Social workers work with multiple interpretations and incorporate several social languages (Donovan 2007). The study respects the systemic approach, which is here described as explorative and creating a reflective space both for clients and for social workers.

Mandin (2007) described social work care proceedings as an example where integration of systemic and psychodynamic approaches provide additional layers of meaning to complex situations, e.g. the assessment of parents of multi-problem families. The systemic approach would advocate connecting patterns of interaction, circular understanding in which all participants are interacting, and be influencing each other.

Circular questioning technique, eliciting new information through different perceptions and attachment of meanings related to the event are all relevant and necessary to the study because of dealing with complex situations and use of a systemic and psychodynamic approach.

Second order cybernetics in systems theory (Hoffman 1981 in Mandin 2007) emphasized the impact of the therapist as an active participant in the system. Social constructionist ideas in systemic intervention suggest the negotiation of reality by all stakeholders of the problem-determined system (Anderson et al 1986 in Mandin 2007). The therapist becomes aware of recursive patterns of influence, e.g. societal meanings, structures and institutions and the family's own problem saturated story. The therapist is enabled to choose a most effective level of intervention.

3.6.7 Social work practice related to families living with HIV/AIDS

As described by Aronstein and Thompson (1998), social work practice relates to case management, individual, couple and family counseling services, services in health care settings, acute care, family involvement and bereavement work in hospice and home care.
Social workers are practicing ART psycho-social assessment and support, HIV related mental health referrals e.g. dementia, are dealing with clinical and ethical issues, facilitate HIV support groups, and deal with related substance abuse.
Social workers provide education on how to talk with parents and children, they do legacy work, permanency planning, practical aspects of care, e.g. housing, services for minority groups, e.g. gay people.
We could add the services rendered to refugees, and the reality that all these services would need to be in place for large groups of infected and affected people and often simultaneously. Hence the need for interdisciplinary work and the training of lay counsellors and service providers to put more of these services in place as set out in the motivation of this study.

Patterson and Keefe (2008) describe social construction theory, applied to intervention for people with substance abuse and HIV infection, as moving past the micro and mezzo-level interventions to macro level intervention. HIV positive substance abusers are viewed by society as having a "non deserving " group status. Social workers are to use methodology that will impact on their social context. Interventions need to address neighbourhood characteristics, e.g. residential segregation, or gang turf. Their interventions need to constructively address low-income, norms that stigmatize homosexuality, and lack of accessible and affordable clinics providing STD treatment, HIV testing and ART. The provision of decentralized clinics and mobile HIV screening teams will help remove the stigma and change the societal view of people that are now gaining access to services. Also local substance abuse awareness and counselling services will help remove the stigma. Instead of objectifying and internalizing the HIV status and maintaining alcohol and drug abuse, upward mobility is encouraged, and the neigbourhood's concerns are addressed. Other community service providers can also be asked to recommend these services (Patterson & Keefe 2008).

In this study the pastoral family counsellors are going to receive training in a holistic manner, which implies relating to HIV/AIDS prevention, education, counseling and support. As mentioned by Cochrane (2006), a constructive approach to community counselling means to transform conditions that exacerbate the problems.

3.7   Contextual and narrative family therapeutic approaches in counselling families living with HIV/AIDS in the context of practical theology

3.7.1 Narrative Family Therapy

Michael White and his associates introduced post modern thinking into the field of family therapy. White's work was to a large extent based on the writings of the philosopher Foucault who stressed the de-centring of the subject and the ubiquity of power

pervading all human interaction. He saw these trends embodied in a pervading discourse, determined by those in power. White suggested that such powerful discourses would serve to maintain the status quo in problem families. Therapy should assist the person to separate from the problem behaviour and look for unique outcomes by escaping the tyranny of the dominant discourse that defined him or her as the problem. White recognized that people have many 'selves' and have lived and owned many life stories (White 1992). Parry stressed another unique implication of working with families: all members of the family, through participation in the stories and sensibilities of the other family members, and through legitimizing their own stories by telling them in their own words, would be entitled to be part of and subjected to the influences of different worlds, different languages and different selves (Parry & Doan 1994).

Narrative therapy would set out to help people living with HIV/AIDS to live their 'preferred stories' and would be an important inclusion in the training model. This chapter revealed some of the discourses that may be dominating their lives, e.g. patriarchy, domestic violence and through a process of deconstructing the power of these discourses, families living with HIV/AIDS are helped to deal with these injustices. They are encouraged to (re)discover alternative perspectives on life and their own hidden strength. In this process, the therapist journeys along and enters a relationship of connective understanding and participatory consciousness (Kotze 2002).

3.7.2 Contextual Family Therapy

Parry and Doan (1994) refer to the obligation of family therapy to seek an ethical stance. In families the other, opposed to the same, is always present as challenge and opportunity. When family members tell their stories, an ethical demand is evoked in the relationship to recognize the mystery which is the other and embrace differences in others and ourselves.

Boszormenyi -Nagy (Nagy) was influenced by the writings of the philosopher Martin Buber, and his notions on the dialogue as foundation of human relationships. The quality of the relationship, the 'I and Thou', is one of openness, directness, mutuality and presence. People give meaning to their world through these relationships (Buber 2002). Nagy added the intergenerational relationship to this concept of dialogue. Nagy's dialectical concept of 'entitlement' in relationships describes the process of receiving through giving which then results in personal freedom (Van Heusden & Van den Eerenbeemt, 1992). Nagy did not specify a philosophical foundation for his approach in family therapy. He proclaimed he was more interested in whether it worked (Den Dulk & Zock 2001). The contextual family therapists Meulink-Korf and Van Rijn linked Nagy's work with that of the philosopher Levinas, who saw man's ethical relation to 'the other' as ultimately prior to his ontological relation to himself or to his relationship to the world. "My ethical relationship of love for the other stems from the fact that the self cannot survive by itself alone, cannot find meaning within its own being-in-the-world, within the ontology of sameness" (Levinas & Kearney, 1986 in Parry & Doan 1994). Meulink-Korf & Van Rijn elaborate on Levinas' focus on the 'other person' and conclude that it is not about altruism, but about a responsibility for the wellbeing of the other person and in the wellbeing of our future world (Meulink-Korf & Van Rhijn 2005).

Contextual therapy places the dominant stories in a multi- generational context and helps the person living with HIV/AIDS to depict the influence of these stories in the life of the extended family. Through careful questioning the therapist and the person would discover how these dominant stories were kept in place and were fuelled throughout the life of the family. Contextual concepts as entitlement, loyalty, indebtedness, legacies are explored throughout the life of the family. Contextual therapy would also look for alternate stories and focus on purposeful identity, an awareness of who one is and would like to become (Van de Kemp 1991), these are important considerations for the development of the training model.

The counselling relationship would adhere to the relational ethic of mutuality and trustworthiness in relationships. "Relational ethics does not have specific moral content,

but rather is concerned with a balance of equitable fairness between people" (Boszormenyi-Nagy & Ulrich 1981:160). Morgan (2000) refers to this aspect of the counselling relationship as engaging in expressions of experience and meaning. It exposes and critiques a person's identity and belief system, without looking at it as right or wrong, they merely exist.

Both contextual and narrative therapy practice multi partiality as a tool in family counselling. Parry and Doan (1994) mention the 'talking stick', whereby each member of the family in turn is invited to express their view. The therapist will ask the binding questions and engage the family in a dialogue of mutual respect. Boszormenyi-Nagy and Spark (1973) relate to a mutual dialogue in family therapy where each generation is faced with the nature of present relationships, explore the nature of commitment and responsibilities of their involvement and increase their reciprocal understanding and compassion. Family members are helped to be freed of scape-goated or parentified roles.

The researcher is aware that multi partiality may not be a well tolerated approach to counselling both in Western and African culture. The presence of grandparents and the possibility for children to be heard may cause opposition in families. Nevertheless, when families come forward, this cultural dilemma can be 'worked through' in the context of the counselling experience and would thus become important key elements of a good training model.

CHAPTER FOUR

LITERATURE REVIEW : TRAINING AND ASSESSMENT

4.1 <u>INTRODUCTION</u>

This Chapter continues to discuss phases two and three of the Intervention Research Model, pertaining to a 'State of the Art' review that is also the literature against which training modules were devised for use in this study.

In this Chapter several approaches and aspects of teaching and learning are discussed. The narrative and contextual approaches to the developing of training materials and the modes of training will be introduced. The role of training guides, assessment models and supervisory design are discussed. The target groups of learners, e.g. church leaders and lay counsellors are described, and their discourses and approaches to spirituality mentioned in order to help establish the fit between the target groups and training styles and programmes, which is one of the key focus areas of this study.

4.2 <u>A HERMENEUTIC APPROACH TO LEARNING</u>

The researcher believes that the postmodern and social constructivist paradigm have influenced the scientific approaches to teaching and learning. In different fields of education, e.g. the training of nurses, social workers, family therapists and pastoral counsellors, a more evidence based and hermeneutic approach to learning has been developed

Learning is about how language shapes the life world it seeks to describe and how the life world shapes language. This hermeneutic circle is a process of interpretation of how educators and learners experience the world and make sense of it (Brown et al 2005).

Wint and Sewpaul (2000) discuss the circular (hermeneutic) approach to learning when describing a Diploma course for community development workers. Learners engage in the classroom and with the community in a process of critical reflection, analysis and action. All teaching methodology is aimed at aiding this process e.g. practical work in the community, writing assignments and participating in small study groups. A constructivist approach to learning emphasises that learners construct learning needs, develop knowledge and test out theories with the community. Thus learning becomes introspective and experiental. The understanding gained from the experience with the community is reflected on in the classroom and new knowledge and attitudes are gained. Self-reflection produces self-knowledge. The course content in the training model would need to reflect the life experiences and context of the learners and promote an indigenous and unifying approach to learning (Wint & Sewpaul 2000).

For the development of the training programme, the researcher combines a moderate hermeneutic approach to learning with a critical hermeneutic approach. This is a similar approach to learning as proposed by UNAIDS at their workshop with religious leaders. They choose dialogue and mutual respect based on ethics in relationships (UNAIDS 2008). The researcher believes that in South Africa there is a legacy of 'being taught what to think' and of 'being denied of cultural practice'. To be sensitive to that heresy and at the same time wanting to address pertaining issues related to HIV/AIDS a moderate and critical approach seems most appropriate.

4.3 OUTCOME BASED EDUCATION (OBE) PROBLEM BASED LEARNING (PBL) AND EVIDENCE BASED LEARNING (EBL)

All three methods are constructivist approaches to learning and focus on the following areas:

- self-directed learning,

- emphasizing the use of small discussion groups as a means for cooperative group learning, and

- promoting the integration of knowledge and practice experience.

The role of the facilitator is to facilitate the process of learning and be a resource for content information. Wilkerson (according to Neville, 1999) states that learners determine their own learning objectives, ways to reach these objectives and learn to evaluate what they've learned. Through community practice, they identify their knowledge deficiencies. The gaining of new knowledge requires the activation of prior knowledge (Davies 2000). Not all the learning is self-directed. The course content or curriculum and practice problem situations may be pre-developed, but can still be facilitated in a learner-directed manner (Neville 1999). This was deemed important to consider given that there were several data sources to inform course content, hence the need was then to use the philosophy of learner-directed participation to optimize teaching and learning in the training model.

Attention should be paid to the training of group dynamic skills to facilitators of small learning groups, as participants have different personalities, come from different cultural backgrounds and are of different ages. Learner-directed facilitation would promote mutual understanding through listening, and sustained discussion. "The facilitator joins honestly as a continuing co-learner" (Knowles, cited in Neville 1999: 393). This point was also deemed important in developing the training model and in ensuring that there was adequate critical engagement and reflection.

The reality of the complexity of themes and discourses surrounding families with HIV/AIDS makes the presented outcome based approach to learning appropriate. The facilitator would truly take the position of 'not knowing'. Many of the training participants have been scarred by life and have many stories to tell either in word or through silence and would need to interpret these experiences into their thinking and skills development. Small groups would encourage full participation and the creation of rich material. The self-directed learning will be encouraged through the availability of a

Reader, which will contain materials that have been mutually decided on by researcher and participants based on the course objectives.

Knowles outlines the following elements of facilitator learning:

- Climate setting (helping learners get to know each other, developing mutual learning resources, developing self-directed learning skills, and to understand the role of the facilitator).
- Planning (deciding on the running, process, and functioning of the facilitation and learning).
- Designing needs for learning (deciding on content objectives, so that the process of learning can take place).
- Setting goals (helping learners to describe clear and feasible content objectives).
- Designing a learning plan (helping learners to design their plan of learning and access to resources).
- Engaging in learning activities (the facilitator considers which elements of the learning process need facilitation and which parts are the learners own or shared responsibility).
- Evaluating learning outcomes (the facilitator considers on feedback mechanisms to enhance the learning process) (Knowles cited in Neville 1999).

These elements are key to successful learning and need to be incorporated into the design of the training programme as they show how best to facilitate a programme that empowers participants in achieving manageable goals in a team setting.

4.3.1 Outcome Based Learning

Outcome based learning is based on competency-based learning and performance-based, criterion-referenced assessment. Learners are required to demonstrate achievements that become gradually advanced. "The learning outcomes are future orientated, learner-centered, focused on knowledge, skills, attitudes and values. They

are characterized by high expectations of all learners and form a base for further instructional decision making" (Van der Horst & McDonald 1997:43).

In the medical field, since the turn of the century, the outcome based model of learning has gained in popularity. Modern medicine, and therefore the task of the physician, has become more social and preventative. Smith and Dollase (1999) together with an interdisciplinary group of course leaders and medical students, determined the most broadly supported abilities of the competent clinician They then developed a core knowledge base, defining the core content in the area of each of the abilities. Interdisciplinary working groups translated the abilities in observable behaviours and designed performance based methods of assessment. The assessment would take place at different levels of the training. Practice based methods included direct community based work, standardized patients, interactive computer instruction and video tapes. An organizational structure was developed of assessment committees who would help facilitate the assessment process of the learners. In order to certify learners competence, progress reports were presented, discussed and new ideas developed (Smith & Dollase 1999).

The researcher considers these aspects important for the training programme as focus is on engaging in learning activities that create ownership, both for the facilitator and the participants. Therefore learning becomes a shared process of building competence. In African culture, performance based learning is developed from a young age. Young children enter the dance circle and show their skills to family and peers and are encouragement to develop more and better skills. The Smith and Dollase model seems important to establish a profile of the abilities of the competent church leader; in doing that the specific family counseling skills training become part of a broader task field.

Brown's nine abilities of the competent clinician consisted of communication and various practice skills, but also self-awareness, self-care and personal growth, lifelong learning, moral reasoning and clinical ethics. The blueprint of the social and community context of health care ability, mentioned that the competent graduate "provides healing guidance by responding to the many factors that influence health, disease and disability. These

factors include socio-cultural, familial, psychological, economic, environmental, legal, political and spiritual aspects of health care delivery. Through sensitivity to the interrelationships of individuals and their communities, the graduate responds to the broader context of medical practice" (Smith & Dollase 1999:18). Some of the required behaviours were to inquire about the patient's value systems and life style in a non judgmental fashion, avoiding stereotypical language and to identify barriers to access of health care resources. Students are expected to recognize and pursue self-reflection of their own cultural and spiritual traditions, as well as gender, class, and sexual socialization experiences and to articulate and discuss that in the training programme (Smith & Dollase 1999).

The researcher was impressed with the afore-mentioned holistic approach in health care. Brown's nine abilities form a good reference for assessment. These would be skills that need discussion with the participants as they are part of life choices. The church leaders are prominent people in 'moral communities' and therefore the researcher would give careful attention to help develop such abilities and integrate them as learning material in the course content of the training model.

4.3.2 Problem Based Learning

Problem based learning presents prototype cases or problem scenario's to the learners, who then enter the interactive process of encountering the problem, using problem solving skills, identifying learning needs, engaging in self- or group study and applying the newly gained skills and knowledge to the same or other presented cases. (Barrows in Neville 1999). Group discussions help to understand the underlying principles and concepts. Learners are throughout the process supported by their facilitators. The facilitator or a peer may provide 'scaffolding' until full understanding and self-direction of the learner is achieved (Vygotsky, 1987). Other learning resources are the library, their peers, and professionals who share enthusiasm and knowledge about their topic. Through this process, the learners structure their knowledge base, develop reasoning

and learning skills, and are motivated to achieve a deeper and sustained sense of learning.

Problem based learning is part of the individual and team work of the participants in the training programme. The scaffolding may be needed for the process of learning and understanding as well in the process of learning practical skills. A counselling role play may be stopped and started again many times to create better skill and understanding.

4.3.3 Evidence Based Learning

Evidence based learning synthesizes problem-based learning with critical appraisal of concepts to be learned and with quality management of learning projects (Eitel & Steiner 1999).

Social work has in recent years undergone a move from opinion-based to evidence-based practice (EBP). Where opinion based work is being perceived as authoritive, the process in EBP is a bottom- up process of engaging with the client to encompass their unique experience with their presenting problem (Shlonsky & Gibbs 2004)

The diagram shows the evidence based practice as a result of a careful integration of the practitioner's individual expertise, best evidence and the client values and expectations.

Figure 4:1. Evidence based practice EBP Model. Shlonsky & Gibbs (2004).
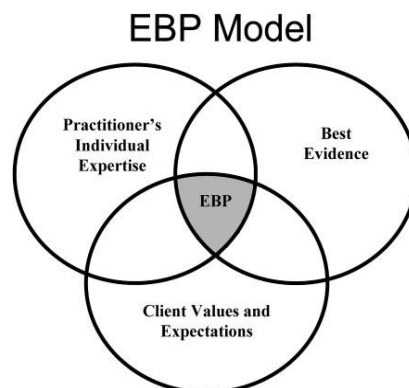
Evidence practice originated in Health Care. Decision making about clinical choices needed to be based on evidence and not on intuition and unsystematic clinical expertise. At the same time the "value laden nature" of clinical decisions required contextual understanding of the patient, belonging to a patient group and community. A systemic approach included sensitive listening skills, compassion and added perspectives from humanities and social sciences (Guyatt & Rennie 2002 in Gambrill 2003).

The components of evidence-based practice are the evidence from research findings, systemic reviews of randomized clinical trials (RCTs) as well as descriptive and qualitative studies, opinion leaders and evidence based theories, the evidence from what the client presents and availability of care resources, personal professional experience and information about client preferences, values and concerns.

Steps involved in Evidence Based Practice (EBP) are:

1. Formulating an answerable question regarding information needs related to practice decisions. The health care profession mentions the PICO format (population, intervention of interest, comparison intervention or status and outcome). The social work profession uses the COPES format (client oriented, practical evidence search) (Gibbs 2003).
2. Tracking down, with maximum efficiency, the best evidence with which to answer them. Search for systematic reviews and evidence-based family therapy or pastoral counseling practice guidelines e.g. the Dulwich centre, narrative therapy website.
3. Critically appraise the collected evidence by asking for its validity, relevance, impact and applicability.
4. Integrate the appraisal with one's professional expertise, client's circumstances values and preferences, available referral resources and then applying it to a practice decision or change.
5. Evaluate effectiveness and efficiency of the evidence-based intervention.
   (Melnyk & Fineout-Overholt 2005).

The researcher can see value in the evidence based approach to practice for the training programme. The above mentioned points provide for an enhanced knowledge and practice base. According to the diagram, the research based evidence doesn't take the place of clinical expertise and incorporates the client's expectations and values. In the design for the training programme, the five steps are followed to derive at training material related to the problems presenting and are given as a task to the participants when they design their case studies. Particular attention will be given to aspects of culture and spirituality as these are not measurable in similar ways as other behavioral changes.

Rubin and Parrish (2007), discussed the above mentioned five points and commented that EBP is client empowering, as the evidence regarding the plausible effects of a particular intervention is shared with the clients, who become involved in the process of the selection of interventions. Other advantages of EBP, as mentioned by Hhlonsky and Gibbs (2004) are the extensive initial knowledge base about the clients, the search for, evaluation and practice of effective interventions, and the emphasis on interdisciplinary understanding and teamwork. The researcher believes that all these points have value and relevance for the training programme as participants are indeed her co-researchers and their empowerment is crucial for best practice to prevail.

Rubin and Parrish (2007) expressed a concern with evidence based work, that practitioners may not always find evidence, and may have to provide interventions without an evidence base. They gave the example of clients with multiple problems, who may not carry a formal diagnosis validity of randomized clinical trials (RCT). Clients with co-morbid diagnosis (e.g. depression, anxiety, substance abuse and personality disorders) were excluded when treating clients for post traumatic stress disorder. Also clients with severe multiple trauma might need longer-term treatment. Empirically supported interventions, e.g. cognitive therapy and exposure therapy are examples of brief therapy.

EBP is also restricted to practitioners who have access to electronic databases. Advances in information technology have increased the speed of access to and the

spread of continually updated systematic reviews of practice information. Many church leaders and lay counsellors come from underprivileged communities and do not have access to a computer. When there is access, time spent on internet may be too costly and computer skills need to be acquired. Hence, the concern raised by Rubin and Parrish (2007) applies to participants in the training programme.

Organisations such as the Campbell Collaboration and the Cochrane Library identify which interventions have the best empirical support.

The client-orientated practical evidence search "COPES" (Gibbs 2003) requires separation of the question in four distinct elements : client type and problem, what might be done, alternative course of action, outcome desired. The questions are then categorized into five domains: effectiveness, prevention, risk/prognosis, assessment, and description (Shlonsky & Gibbs 2004). After finding the evidence, the practitioner would still need to critically evaluate these reviews about the quality of the research and idiosyncratic client needs. When practitioners were trained in other approaches, which may not be appraised as best evidence, they may be overwhelmed by the evidence and fail to appraise it or rigidly adhere to new treatment manuals without adhering to therapeutic alliance with the client and their experience as a practitioner. Another risk is if practitioners selectively find evidence that would support their existing practice base and not necessarily be the best evidence (Rubin & Parrish 2007).

The researcher would agree that it takes practice to arrive at the required results. Then the practitioner needs to carefully consider the match between the client's situation and the available practice model. The whole process needs a practitioner who is committed to evidence based work and preferably works in a team where modalities are discussed and shared with other team professionals and participants who as co-researchers, are partners in the forward planning of the model. When practiced well, the method would create a wider ranch of treatment option and skill development.

The EBP process accepts alternative sources, e.g. case reports, clinical descriptions, qualitative studies, correlational studies, uncontrolled pre and posttest trials. Thyer (according to Rubin & Parrish, 2007) argues that if these are the best sources available, then they are acceptable for professionally guiding the practitioner. It seems

important to find the right balance of the best evidence of certain studies and studies with lower internal validity, that may better fit clients' unique attributes, circumstances, values and preferences. "Qualitaitve studies might generate deeper tentative understandings of client perspectives" (Rubin & Parrish 2004: 419).

To evaluate their application of the intervention, practitioners are advised to use a single-case design. The concern here is the time constraint and therefore the lack of evaluative information of effectiveness and efficiency. "Practitioners would need to adopt a process of lifelong learning that involves continually posing specific questions of direct practical importance to clients, searching objectively and efficiently for the current best evidence relative to each question, and taking appropriate action guided by evidence'' (Gibbs 2003:6). Constant reflection for best practice to prevail is necessary although it is time consuming but important for adoption in the training programme.

Sexton argues that accountability is mostly important in evidence based counseling practice and that 'best practice' is concerned with the service costs, knowledge base and competence of the counselor, which is supported through outcome based research. He mentions the "art versus science" and "research verses practice" debate as irrelevant, as counselors become highly efficient and skilled in their practice and informed by evidence based research. Sexton promotes the practice of empirically supported treatments (EST), which are evidence-based systematic counselling intervention protocols. Lambert (according to Sexton 1999) states that while theoretical orientation or model only accounts for 15 % of the effective outcome of counselling, these protocols would also attribute to common factors of successful counselling as to a collaborative counselling relationship, the value of experiential learning and acquired and experienced action.

The researcher would be concerned if the EST's for personal and familial problems would become part of the training curriculum for pastoral counsellors, that the complex social processes might be minimized. Church leaders may be tempted to a literal application of knowledge and counselling skill and procedure, which might take away their warmth, empathy and natural ability to take the role of the spiritual counsellor. In

the training model, the EST's would need to be contextualized and appraised by the church leaders.

4.3.4 Evidence Based Family Therapy Practice

The field of family therapy has also been challenged to show an evidence base (Larner 2004). Soydan (2006) makes mention of the 'gold standard', a systematic review by independent investigators, which requires randomized control research and the development of a procedural intervention or treatment manual. Several forms of family therapy, e.g. structural and cognitive-behavioral therapy, have been supported by randomized treatment control trials (RCT's).

Shlonsky and Gibbs (2004) agree that qualitative studies are essential for understanding and explaining people's behavior, but they continue to suggest that because of shortage of social work studies that are presenting information based on random assignment, other disciplines need to be approached to find current best evidence.

Melnyk and Fineout-Overholt (2005) describe how the use of narratives informs clinical understanding and experiential learning. When nurses tell and write narratives in the first person, they describe clinical knowledge and wisdom, taken-for-granted understandings, learnings from patients and families. Articulated narratives can be reflected on, interpreted, evaluated and provide questions for further research.

Larner (2004) proposes the systemic-practitioner model over the scientist-practitioner model and ascribes a client-consultative model to narrative family theory. Evidence of a successful therapeutic outcome is based on more than the right choice of therapeutic method. Client resourcefulness, forming empathetic, collaborative and affirmative client-therapist relationships, and engaging client's expectation and hope for change, as reflected in their personal and relational history, are all influential for a successful outcome of therapy (Larner 2004).

The researcher would agree that evidence carries different meanings to a positive client outcome. Specifically in long-term counselling the client-consultative model seems helpful for the client to own the therapeutic process. For this study a client-consultative model creates an attitude of humility with the participants and allows for scaffolding in order to learn the complicated skill of being a helpful counsellor.

Gergen distinquishes between constructivism and social constructionism. The latter relates to a person in contact with others, the family and community context. This construct between people allows discussion of social, cultural and political implications of the problem situation as presented in the counselling session (Gergen 1989). Social constructionist, narrative and systemic family therapy would require an evidence base, which is grounded in empirical research, relating to the real-life complexity of the therapy process, including personal narrative, relational processes, ecological influences and psychosocial context (Larner 2004). Family therapy practice becomes a research modality in itself, when discourse analysis is taking place in the actual family therapy sessions (Roy-Chowdhury 2003).

To further evidence based practice in family therapy, suggestions were made to develop manuals or protocols from multiple-source information, practice based experience, client feedback and satisfaction, practice research networks, and data bases of pragmatic case studies (Larner 2004).

The social constructionist choice in therapeutic method is evidence based, but informed by language as an activity where families jointly construct their worlds and dialogue in finding generative ways of living together (McNamee 2004). The starting point in the integrative practice are the unique narratives of people in their family and community context. What follows is the practice experience of the therapist in the application of relevant therapy techniques. McNamee proposes engagement in a conversational process of meaningful, transformative dialogue with different methods in family therapy, in order to bring resources together and expand or alter the therapist's own models, techniques and assumptions. These models and techniques become discursive options. The dialogue between therapist and client creates meaning, whereby both participate in

the unfolding process of how things might come to be. The therapist is present and responsive. In relation to the training of family therapists, McNamee poses the question whether students would first need to be trained within one particular model and have worked with a number of clients in a number of contexts before they can start developing an integrative approach to therapy. Her concerns are shared by the researcher in asking : could learners be trained straightaway within the integrative model and experience the 'not knowing' and 'becoming'? The concern is then with the standard and method of evaluation and the generativity of a training programme (McNamee 2004).

The researcher would agree that the choice for evidence based work would be to seek integration of methodology. She would prefer to firstly engage in dialogue on theoretical underbuilding of practice methodology which is considered important because theory forms the basis for practice and reflection thereof. Thus integrating social constructionism with hermeneutics made the researcher choose the methodology of narrative therapy and contextual therapy..Both are integrated in the training programme in this study.

Flemons et al (1996) believe that there is place for diversity in understanding of problem situations and ways of conversing with clients. Evaluation judgments need not be objective to be valuable, helpful and ethical. They developed a scheme for evaluation that integrated the individual differences of the supervisors and a set of common values that they all held in their therapeutic relationship and process, namely :

 (1) respect for the interpersonal context

 (2) shared responsibility for the therapeutic reality

 (3) language and creation of meaning as a therapeutic tool.

The ethical stance hereby developed would define the relationship between supervisors, students and clients. This scheme for evaluation contains 32 practice skills

or competencies which have been derived through ongoing conversations between supervisors and students and through qualitative evaluation research, culminating in assessing the evaluation scheme for trustworthiness and transference.

This evaluation scheme was deemed necessary and adopted for the evaluation of the pastoral family counselors in the present study and will be discussed in Chapter five of this report.

4.3.5 Evidence Based Practice In Pastoral Care And Counseling

Patton (1993) described a move in pastoral care from the classical paradigm of "Scriptural wisdom, historical awareness, constructive theological reasoning, situational discernment, and personal empathy" (Oden, as cited in Patton 1993:95) to the clinical paradigm of experiential and reflective participation, influenced by the clinical pastoral education movement (CPE), which trained pastors in supervisory skills. The clinical paradigm was strongly individualistic. Pastors were trained in psychopathology and issues of personality, and pastoral care and supervision became more professionalised. A further shift took place in the last 40 years to a more communal contextual paradigm. Pastoral supervision became replaced by pastoral consultation. Where the supervisor had ultimate responsibility for the ministry that the student performed, consultative assistance did not imply responsibility by the consultant for the activities performed. The relationship was voluntary and one of mutual learning. Hunter (2001) mentioned that within the communal contextual paradigm, pastoral care is less concerned about religious institutions and organizations and more focused on 'creating community' in professional secular settings. CPE programmes have been revised and more emphasis is put on context, narrative, cultural diversity, and issues of gender. The training is mainly attended by lay counsellors, predominantly women and participants from minority groups. Clinical supervision has become less authority based. Both long term and short term pastoral counselling is labour intensive and costly. In America pastoral counsellors are licensed and certified through secular professional organizations and

become psychotherapists. Feminist and womanist pastoral theology have supported pastoral theology as a discipline. Pastoral theology thus presents an integrative, contextual, praxis-orientated form of inquiry (Hunter 2001).

The researcher would prefer an integration of above mentioned paradigms. Within a more professional, structured and informed approach to pastoral counselling, the Scriptural wisdom as a narrative resource emphasised contextual diversity, which was a significant component in the study.

Greer (2003) mentions that the pastoral counsellor needs "insight, hunch, approximation and expert opinion" (Greer 2003: 401). She adds that the pastoral counsellor also relies upon faith and divine guidance. Pastoral counselling as academic discipline and profession adds to the work of the pastor. She challenges pastoral counsellors to apply themselves to basic skills development and learn statistic methodology. Greer states that "with relatively little further investment in training time, pastoral counsellors could become recognized participants in the general mental health community" (Greer 2003:401). Greer encourages pastoral counsellors to maintain their identity within their research studies, which embodies continual reflection and alternation between faith and action (Greer 2003).

The researcher would agree that the specific vantage point of spirituality would add to the existing knowledge base of mental health. Specifically in African culture where health and spirituality are intertwined, pastoral counsellors could inform practice through their involvement in participatory research studies. There is an extensive body of knowledge created through integration of religion and clinical psychology (Van de Kemp 1991).

Brown (1999) reflects on the changes experienced in hospital chaplaincy. Patients spent shorter time, so pastoral care and counselling is limited and only provided to patients who request the service. The chaplaincy received training through clinical pastoral education (CPE). The joint commission of the accreditation of pastoral services

assesses the competence and professional ethics of the chaplain. They provide a profile and religious care standards for the departments of pastoral care, mostly concerned with the availability of service provision. Chaplains must have a theological degree and be able to document their ongoing education, and chart patient care activities. Another requirement is the creation of a spiritual care plan and clinical pastoral pathways. Cusick (according to Brown 1999) designed a pathway from the perspective of the chaplain for ministry to patients with bone marrow transplants and stem cell transfers. He also described the spiritual themes that surface for these patients. CPE and pastoral care departments are working together to assess what it means to be able to provide culturally sensitive, religiously appropriate, and informed pastoral care (Brown 1999).

For the development of the training programme, the merge between a professional and a spiritual relational approach to practice can be achieved in creating spiritual care plans and pastoral pathways for families living with HIV/AIDS.

Evidence based practice in pastoral care and counseling relates to the professional ethics of the pastor. Four of the theological departments of Universities in Southern Africa, together with the World Council of Churches have invited pastors to seminars to further their knowledge on critical ethical topics. Haspel, a visiting research scholar from the University of Marburg provided lectures on the topic: "Christian and sexual ethics in a time of HIV/AIDS. A challenge for public theology". Haspel commented on the challenge for the church, not only to relate to the medical and social problems related to HIV/AIDS, but to develop a theological concept in dealing with HIV/AIDS, using theology and anthropology, and to develop a respective sexual ethics in order to provide ethical orientation and help people to live responsively in a changing world with HIV/AIDS (Haspel 2004).

The researcher finds it encouraging that there is such emphasis to help establish a contextual ethical dialogue, resulting in an integrated ethics related to sexuality and HIV/AIDS. The challenge would be to continue this dialogue within the training programme and provide ways of discussing similar topics within family structures.

What also warrants mentioning as part of the 'state of the art review' is the interdisciplinary studies conducted by the Theology Departments of several Universities in Southern Africa. Many of these studies were aimed at poverty alleviation and pastoral care and counselling related to people living with HIV/AIDS. The studies were aimed to inform the church communities about the realities surrounding HIV/AIDS and to create a provision of practice modalities. The departments provided rich description and narratives, creating awareness of cultural discourses and community resilience.

Example of such studies are the research conducted in 2003 at the Department of Practical Theology in Pretoria titled "Unheard stories of people infected and affected by HIV/AIDS about care and the lack of care" (Muller 2003); the study that was conducted by the Department of Practical Theology and Missiology's unit for religious demographic research (URDR) at the University of Stellenbosch in 2003 titled: "Congregations as providers of social service and HIV/AIDS" (Erasmus et al 2004) and the School of Religion and Theology of the University of KwaZulu Natal, being affiliated to Sinomlando Centre, for Oral History and Memory Work in Africa, and seeing it as its mission "to integrate as closely as possible teaching, research and community development" (Denis 2005: vii).

These recent developments point to emphasis on and connectedness with the local church communities in their provision of care and on creating understanding about cultural and contextual dynamics at community level that hinder the reduction of the spread of HIV/AIDS. These studies indicate the importance of ongoing attention to context whilst simultaneously offering therapeutic counselling to families and communities.

4.3.6 Evidence Based Community Practice in Social Work

Franklin and Hopson (2007) mention behavioural therapy, cognitive behavioural therapy, family therapy, and brief therapy, as well as psycho-educational group programmes and family treatment courses as building blocks for many evidence based programmes (Franklin & Hopson 2007). They identified that evidence based community practices share some common characteristics, that can be incorporated in training of social workers, to ensure that students have the basic skills to implement a range of effective practices.

They refer to the skills and other components as mentioned by Schinke et al (2002).

1. "Program content on general life skills or a combination of knowledge and skills
2. Opportunities to practice newly-learned skills through modelling, practicing behaviours, and completing homework assignments, such as practicing skills at home with family members
3. An emphasis on the importance of family, school, and community support for behaviour change
4. Use of materials that are clear and easy to follow, such as written manuals with step-by-step guidelines for each session
5. Curriculum duration of 9-12 weeks
6. A consistent prevention message communicated by families, schools, and community members
7. Group and family interventions that emphasize relationship building
8. Emphasis on strengths rather than deficits
9. Materials tailored for the target group and bi-cultural facilitators when offering the curriculum to minority youth
10. Implementation that is consistent with curriculum instructions
11. Inclusion of booster sessions"   (Schinke et al 2002:395).

Schinke et al (2002), designed this material for working with substance abusers and their families. Evidence based materials are presented as 'easy to follow' and the

practice of life skills is clearly described and monitored in their programme. The emphasis is on creating supportive structures to overcome problems within families and communities. The researcher would also promote such a strength based response to complicated family problems, combined with the provision of family therapy and individual counselling in the training model. Of note is that churches have the capacity to put all these activities and services in place, making inclusion feasible for incorporation into the training model/s.

4.4   PROGRAMME DEVELOPMENT

This section will be concerned with phases three and four of the Intervention Research Model, referring to the design and development of an observational system and the specification of procedural elements of the intervention, as well as developing a prototype programme. The application of phases three and four are described in Chapter 5, as well as the application of Muller's Post Foundationalist Practical Theology 7 movements for the development of the training content and materials.

The researcher considered the following model for programme development.

The transformative design describes the importance of culturally relevant training and practice.

4.4.1   Transformative Design

Sealey-Ruiz (2007) described the culturally relative curriculum (CRC), a transformative approach to learning as relevant to the African culture. Female African training participants were seen to apply their existing knowledge to what they were learning. A culturally relevant training programme would validate language, regard (group) identity and affirm participants' goals. Transformative learning provides opportunity to participants to deconstruct negative discourses and find praiseworthy aspects of their culture. Readings and coursework need to be relevant to the participants lives and their experiences form the basis for class discussions and for their assignments. The

transformative approach to learning is relevant for the training of pastoral family counsellors, as existing knowledge and learning goals are taken into account, along with culturally relevant discourses.

4.4.2 <u>Tools for programme design</u>

There are several guides available that help to communicate the course outline and content to the prospective students. These are listed hereunder.

4.4.2.1 <u>Course mapping</u>

The course map provides a picture of the course syllabus. In one or two pages the learner or any other interested person can see what is expected and what the training programme provides. It shows the course topics as well as reading assignments and requirements for assignments and tests. A course map is relevant for the study, as it provides a quick overview of what the course entails.

4.4.3.2 <u>Study guide</u>

A study guide is a book that contains the:

- reading assignment
- course objectives
- course rationale and vocabulary
- activities
- learning topics

The study guide helps to learn more independently, creates a realistic learning process, and helps monitoring the learning progress (Hudson, Ormsbee & Smith Myles 1994).

The researcher would seek to integrate systemic and transformative approaches to programme development for church leaders. The systemically ordered learning style would provide a structure and active learning tasks that would invite interpreted and applied levels of comprehension. The researcher would value and show respect for the church leaders' own prior knowledge or experience and through a trusting relationship help learners to build on this knowledge and experience, and acknowledge possible knowledge gaps, errors or confusion (Pololi et al 2001).

4.5   VALIDATION AND SUPERVISION

The next session is concerned with phases four and five of the Intervention Research Model and discusses selection and assessment criteria for the training participants and approaches to supervision.

4.5.1 Counselor competence

Counsellors are competent when able to present in a professional manner, being other centred, establish therapeutic alliance, maintain a therapeutic frame and consider environment (Wheeler 1996). Counselling training and supervision would need to concentrate on these five areas of expertise.

For the training programme, these competencies would need to be established with the course participants as learning objectives, and further discussed in order to be desired and practiced throughout the learning experience.

4.5.2 Selection of students

The selection process mostly starts with an application form. This form may include a more or less extensive personal autobiography. References can be sought and interviews conducted. Some courses encourage self selection and participants are given the opportunity to develop and achieve the course objectives during the first part

of the course. Ethical difficulties may emerge when participants are competent in fulfilling the formal criteria for passing the course, but have presented with personality or interpersonal problems on the course (Wheeler 1996).

For the training programme, the researcher would suggest to people who present with personal or relational problems at the level of application to rather first seek professional help and then reconsider becoming a counsellor. Church leaders can also take that stance and first find professional help. During the cause of the training personal problems may surface and often as unexpected by the participants. The trusting atmosphere in the training group may provide a level of healing or encourage the participant to look for professional help. The perspective of the 'wounded healer' as discussed by Augsburger (1986) can be applied when participants are dealing with HIV/AIDS in their homes and are trained to become family counsellors to other families.

4.5.3 Assessing competence

Setting learning outcomes relates to participants' initial level of competence, length of the course and additional resources. Objectives must be realistic, attainable and take into account what employment or activities participants are likely to partake in at the end of the course and of standards imposed by the South African Quality Assessment (SAQA) (Wheeler 1996).

To be registered on the NQF, a qualification must represent a planned combination of learning outcomes with a defined purpose, intended to provide applied competence and a basis for further learning and add value to qualifying learners in terms of status, recognition, marketability and employability. SAQA (according to Wheeler, 1996) states that the qualifying learner is expected to demonstrate the desired qualities which instil in training participants the capacity for lifelong learning, regardless of the specific learning area or the content of the learning; and specific outcomes to be achieved in a particular learning area, which are contained in unit standards as registered statements of desired outcomes and their associated assessment criteria.

Assessment needs to be made of theoretical understanding, counselling capacity and competence, counselling ethics, self development and relational skills (Wheeler 1996).

For the training programme, the researcher would envisage designing a programme of ongoing training and assessment and provide supervision to participants in order to assess the above mentioned competencies.

4.5.4 Assessing methods

Formative and summative assessments may include: tests of knowledge, survey assessment, examinations and tests, seminar presentations, essays and case studies, learning journals, self and peer assessment and supervision. Assessment tools need to be devised or amended. Other assessment tools are competency scales, the use of audio tapes or DVD's, role play or the use of real clients.

The researcher would carefully select assessment tools that enhance the knowledge base and help participants reflect on their counselling competency and methodology. Written assignments provide insight in 'language'. The course participants would need to be able to write in the language that they are comfortable with. The reality of complexity and contextual influences warrants a diversity of assessment tools.

4.5.5 Assessors

These can be the course staff, though one needs to guard against personal bias and a comprehensive assessment and team approach could be beneficial in ensuring objectivity by standardizing assessment by different assessors. Supervised clinical practice would require a placement manager, who takes responsibility for work carried out, and can provide a counsellor performance overview, e.g. reliability, attitude and client satisfaction and attendance records. Assessment through supervision may not be helpful as it could inhibit counsellors' open discussion of thoughts, feelings, hunches, mistakes, dilemmas and fears. Self assessment and peer assessment need reflective

and critical skills, which counsellors would develop during their practice and training. These skills deal with personal development and client assessment, interaction and management (Wheeler 1996).

Mcleod (according to Wheeler, 1996) promotes a social constructionist view of the counselee as the lay consumer, who can assess the counselling experience and comment on the experience of being helped and understood. External accountability to an external assessor can be important in achieving unbiased assessment results and promote standardization.

For the training programme the researcher would promote the establishment of community based counselling and training rooms that are coordinated by a placement manager. The participants would provide counselling services to the community in a structured and professional manner. The researcher would choose supervision as an assessment tool, as it provides insight in competency levels and is part of an ongoing growth process.

4.5.6. <u>Hermeneutic approach to validation and supervision</u>

Students' assessment from a critical hermeneutic perspective, relates to the awareness of dealing with complexities of interpretive processes.

Ricoeur (1981) makes the distinction between the hermeneutics of faith and the hermeneutics of suspicion. The hermeneutics of faith is an exercise of understanding and unraveling multiple levels and meanings in text. This is a sensitive, empathetic, and respectful way of assessing students and in this study will be adopted since participants are valued as co-researchers.

The hermeneutics of suspicion is an exercise of critically exposing ideology in student texts, which disguises social inequalities. The assessor exposes the reality of exploitation and oppression.

The realization that these modes of interpretation are both valid and often function parallel or can be seen as two sides of a coin, makes the task of the assessor more important. Merely providing a mark or a brief comment would be insufficient.

Selection and certification (summative assessment) and formative and diagnostic assessment, need thorough attention to the life world of the student text in order to create understanding that will warrant a judgment that will produce change (Graaf et al, 2004).

As mentioned before, the researcher prefers the combination of moderate hermeneutics and critical hermeneutics. The process of deconstruction and reconstruction of social reality needs the careful unraveling of life experiences and attached meanings. The unique stories of faith in personhood, family life and significant relationships needs to be told. In the process of assessment, the researcher would create a therapeutic alliance with the participant and with the group.

4.5.7 <u>Narrative approach to validation and supervision</u>

A narrative approach in the supervision of counsellors is described by Boeckhorst (2006) as a process of reflection that takes place between the supervisor and counsellor. The use of language and narratives are the tools with which reality and meaning are constructed. The narrative approach in supervision engages directly with the client, to create more perspectives, meaning, reality and a collective understanding of what occurs between counsellor and client, which then becomes a unified story. The primary story line is the dialogue between supervisor and counsellor, to which the client is a witness. The 'stuckness' of the counsellor is the leading motive. The second story line is the dialogue between counsellor and client. The supervisor is witness and the problems of the client are the leading motive. The third story line develops out of the interaction between the first two and supports reflection thereof. The supervision dialogue helps the counsellor to narrate the story and create clarity and meaning through a process of defining (in an associative manner) and analyzing (by focusing on a particular detail in the story). The supervisor starts working with the presented story

and re-visits parts of the dialogue, looking for symbols and metaphors in the story, in order to emphasize the way that the counsellor interprets and gives meaning to the story. The supervisor will also look for 'knots', incoherence in the presented story, which often are masking untold experiences, conflicting or painful and by pointing to those, the supervisor opens ways to find alternative story lines or new details which thicken the presented story. Through this process of deconstruction, the supervisor creates spaces for alternative perspectives, descriptions and understanding, which help change the view point.

Both the supervisor and counsellor create a double perspective through a regular interchange between dialogue and supervision dialogue. The supervisor can make use of a one-way screen or can be seated in a corner of the counselling room. The double perspective can be strengthened by the use of a reflecting team (Boeckhorst 2006).

The researcher would encourage transparency in the supervisory relationship. For all stakeholders this remains a learning experience in which knowledge, skill, wisdom and ethics come to the fore. One way screens would be preferred, as it makes it possible for a team to be part of and contribute to the learning experience. Other narrative constructs that have relevance for the training programme such as outsider witnessing will be incorporated to enhance the quality of intervention.

Freeman et al (1999) mention the importance of working with the supervisee's pre-existing knowledge and therefore the recognition of their own experience, and feelings. This would result in the deconstruction of the hierarchy between supervisor and supervisee. Michael White (1989) cautioned supervisors to recognize that supervision "might encourage participants to surrender their own 'hard won' knowledges and submit to the authority of teacher/supervisor". "It is important for the supervisor to incorporate the participant's lived experience, to facilitate their being able to "enter into the story and to take it over and to make it their own" (White 1989 : 33-34).

The researcher would agree that supervisors would need to engage with the participants in the exciting endeavour of helping people to create understanding and model the attitude and skill of listening well in order to reach a level of understanding and encourage clients and participants to listen for unique outcomes. Importantly, the supervisees' lived experiences and knowledges will not be overlooked as inferior and 'relinquishable'.

Freeman et al (1999) describe the development of training material 'learnings' as a process whereby the participants narrative interviews with clients are discussed, by means of narrative questioning between supervisor and participant as 'collaborative inquiry' A 'problem ethnography' is developed through this process of 'thick description' and 'the unique account of the relative influences' of both the problem and the person. The 'problem ethnography training interview' provides an understanding of culturally oppressive ways in which the problem has an influence on the person and the liberating influence that the person has over the problem.

The training model is developed in a format for inter-vision between supervisees. The interview structure contains questions about the following issues:

- The externalization of the problem from the person
- The relative influence of the problem on the person
- Unique outcomes
- The relative influence of the person on the problem

For Freeman et al (1999) narrative questions were devised by the interviewer and co-interviewer and the remainder of he group became a reflecting team, which discussed the questions and the responses of the supervisees. This process enhanced the group's cohesion and increased each supervisee's level of confidence for implementing the discussed concepts in their practices.

The researcher would encourage this approach to supervision as it provides a model for intervision. 'Problem ethnography's' could be developed and used as case studies for

further training and group discussion. Counselling rooms in different areas of KwaZulu Natal may provide various case scenarios, which will provide more learning opportunity.

4.5.8 <u>Validation and supervision in pastoral counselling</u>

Boyd and Lynch (1999) mention regular supervision of professional counselling practice as part of the professional approach to counselling. Supervision is aimed to help the counsellor think about his or her work with clients and to maintain the therapeutic frame. The supervisor needs to be a trained and experienced counsellor with supervisory skills. Many pastors do not receive formal supervision or are supervised by another pastor, who may not be a trained counsellor. Many religious organizations would maintain a 'ministerial frame' and expect the pastoral counsellor to be 'always available to all'. The minister is called by God to be a servant and shepherd. This perception may create a sense of being owned and a heightened sense of responsibility, with risk of loss of personal boundaries. When a pastoral counsellor's sense of value and self-image is depending on this discourse, then it will be harder to impose limits, as the pastor wants to be seen and known as a helping person. Effective supervision may help the pastoral counsellor to establish an appropriate therapeutic frame, to manage client's frustration properly and empathetically and use it to the client's benefit within the counselling setting (Boyd & Lynch 1999).

As described in Chapter three, the church leaders' and congregations' perception of his or her role and identity are important for the manner in which he or she performs the different tasks and obligations. The reality of church leaders in most of the rural areas in KwaZulu Natal is that they would oversee a number of congregations and would provide supervision or consultation to the local residing assistant pastors or elders. The therapeutic frame as discussed in the training programme would need to be contextualized to the realities that these church leaders are facing.

Steere (2003) discusses the different levels of responsibility in supervision. Clinical supervisors are seen to balance their attention between the personal learning process of the counsellor and their concern for the wellbeing of the clients e.g. counsellors who are taking excessive control or who talk too much.

The authors mention 'live supervision' of a family therapy session , where the supervisor assumes full responsibility for the course of intervention and provides clear directives from 'behind the one way screen', and the supervision of a group co-leader, whereby the supervisor would only guide at crucial moments, when the group is at a loss. Pastoral counsellors have different learning styles and different attitudes towards supervision can come to the fore. Some would deny the impact of the supervision, others would submit without understanding, and yet others would respond with embarrassment, or pretend to be too busy or have nothing to say. Reflection upon the supervisory relationship helps to build a working alliance.

What can be recognized in the supervisory relationship are parallel processes, whereby the pastoral counsellor identifies with the counselee and subconsciously presents a combination of emotional material to the supervisor. This common experience can cause frustration, but reflected upon, can provide reflective collaboration. Another example is the isomorphic character of supervision, whereby a fighting family, causes a chaotic reflecting team and a critical supervisor.

The researcher would agree that reflection and openness in the working relationship between supervisor and participants is of crucial importance. Wayne Hill mentions five stages in the supervisory process of supervision in pastoral care and counselling that are significant for supervisors and trainees in the training programme: The hesitation stage, the irritation stage, the consolidation stage and the collaboration stage.
Throughout these stages the therapeutic alliance is paramount for the participants to "develop trust and respect for the supervisor's emotional availability and clinical skills" and to "reflect upon the mutual learning experiences and relational and theological meanings" (Wayne Hill 2001:6).

4.5.9 <u>The Person Of The Counsellor</u>

This section will discuss the person of the counsellor related to the difficult material that counsellors are exposed to and will explore ways that they can contain this material within healthy boundaries.

A postmodern constructivist view promotes the perspective of the observer being part of the observed. The counsellor joins the client in the therapeutic reality, which is experiential and subjective and therefore the counsellor takes a self-referential position. How does the counsellor create a perspective and interprets observations in the counselling relationship?   A recursive process evolves of self-reflection and analyses of theory and research that are interpretive and meaning orientated. A reflection takes place of the counsellor's own personality and history, as much as that of the client. Being conscious of their own past experiences and memories and defining experiences every day, counsellors become better equipped to listen to difficult material, reflect on it and manage it with their clients (Valkin 2006).

Human reflexivity also pertains to cultural understanding (Gergen 1989). In the South African context pastoral counsellors often belong to families and communities that are dealing with poverty and HIV/AIDS. Gender inequality may be well accepted within their church culture. Within a church environment, the participants are exposed to institutional dynamics and community involvement. Both within the training of counsellors and the supervision of counselling practice, the participants need to reflect on their past experiences, memories and perceptions relating to gender, age, race, religion and culture. Family of origin work will assist the participants to reflect on themselves within their family relationships and gain a clearer understanding of how their family functions. According to Valkin (2006) this creates the opportunity for them to come to terms with relationships in their families and deal effectively with counter-transference reactions, an important reality that if left unattended, can render the training programme incomplete and unsuccessful.

Ringel (2001) mentions some of these counter-transference reactions related to counselling clients with HIV/AIDS. Working with people that are dying of AIDS can trigger complicated emotions in the counsellor such as fear, (survivor) guilt and anger. Often counsellors experience a strong sense of helplessness. The living environment of multiple deaths is still an ongoing reality. Supervisors would need to develop a heightened self awareness and self reflection to be able to help participants deal with their own feelings and attitudes towards death and dying (Ringel 2001).

The researcher agrees with Valkin that the person of the counsellor needs full attention, specifically in the South African context, where counsellors come alongside people who suffer multiple losses. Transference may happen when emotions have not been experienced in a 'containing' environment. The training programme may help participants to become more open to their own life situations and a peer group may also help to share some of their burdens. The researcher would also pay attention to their lifestyle and would build the aspect of 'self care' into the programme.

4.5.10 Existing training programmes in Contextual and Narrative Family Therapeutic Skills.

This is part of the 'state of the art' report as described in phase One of the intervention Research Model.

The researcher did an internet search on family therapeutic counselling skills training for church leaders and lay counsellors in July 2008. At the time, there was no result which encompassed all entries. Several Bible Colleges and universities, e.g. the University of South Africa provide training courses for lay counsellors in pastoral counselling skills. The Zimbabwe institute of Systemic Therapy, provided a 10- day basic systemic counselling course for the Seven Day Adventist Church in Zimbabwe. When the researcher conducted training for this denomination in South Africa, the Zimbabwean coordinator mentioned that the course in Zimbabwe had been lacking a spiritual component.

At several Universities pastoral family therapy is offered at a Masters level, e.g. the faculty of theology at the University of Pretoria. The Department of Social Work at the University of KwaZulu Natal, has extended their Family Therapy Module to the post graduate students from the Department of Religion and Culture (Partab & Kasiram 2004).

4.5.10.1   Schools for family therapy in the Netherlands

The researcher visited two schools for family therapy in the Netherlands in 2005, who provide contextual family therapeutic counselling to church leaders and lay counsellors. The researcher updated her information about these training facilities through an internet search. Both schools use contextual therapy as well as narrative therapy in their methodology. Both programmes are linked to Universities or Academies and provide short term training to lay counsellors. Both organisations are also involved in training at post graduate level. The Masters programme is a three-year programme. Following are details of the programme of 2 schools for contextual pastoral counselling in the Netherlands.

1. The school for contextual pastoral counselling in Ede (the Netherlands).

The programme coordinator of the 42 hour training programme for church leaders mentioned that at present the pastors would need more philosophical under-building and are not associated with academic and psychotherapeutic circles.

The short course is more (self) reflective and contains 42 hours of which 28 hours are spent on genogram work. The course content is focused on the contextual 'language' which participants are learning to speak and put in practice. They study from a Reader. The course requirements are related to the capacity and willingness to enter a process of reflection and learning of new concepts. The participants are encouraged to use the new skills in their work environment.

2. The training programme for contextual pastoral counselling in Doorn (the Netherlands).

This is a two year programme in which participants spend 8 weekends together. The first year is mainly spent on theoretical work and the second year the participants meet for group supervision and have started to practice family therapeutic counselling skills in their own pastoral practice. This programme also makes use of a Reader.

Both programmes work from a relational theological perspective where they position themsel ves in relation to God and the 'other'.

The researcher has integrated ideas from both models into the design of the study, specifically related to the reflective work and the training of specific methodology such as in multi partiality in family counselling.

4.5.10.2   **Centres of healing**

Although the pastoral counsellors are not specifically trained in contextual and narrative family therapy skills, the national coordinator of the centres practices as a family therapist and is an ordained Methodist minister. Dr Klein developed the 'centres of healing' model in the Gauteng area, which is enabling local churches to develop counselling and support structures. The centres operate integrated with the local communities and are designed to be self-sustainable. Dr Klein developed this ministry since 2009. The researcher entered collaborative conversations, in order to complement training and related services. Dr Klein mentioned a theology of partnerships, whereby networking is translated into "the basic and essential values of serving, caring and sharing together for the sake of the healing and transformation of the whole body-the community, society and family (Klein 2009:68).

The next chapter covers the presentation of the field research results.

CHAPTER FIVE

RESULTS AND DISCUSSION

5.1   INTRODUCTION

As discussed in Chapter two, various methods of data collection were used to inspire the literature study, and to verify the information found through the literature study relating to the life world of HIV positive families and the action fields of the pastoral family counsellors. In this Chapter those methods are further discussed and the findings (verifications) analysed. The focus in this Chapter is mainly on the problems people living with HIV/AIDS face and the facilities already in place to help them deal with these, as well as the perceived need for further facilities and possible training. Comparisons with the literature will be made where applicable. Also discussed are the implications of the findings for setting up a training programme in family therapeutic counselling skills for church leaders and lay counsellors.

5.2   PRESENTATION OF THE FIELD RESEARCH

5.2.1 RESEARCH FINDINGS

The field research as presented under the operational steps of the Intervention Research Model is adapted from De Vos (2001:385). The first two steps are:

Step One: Problem identification, analysis and project planning.

Step Two: Information gathering and synthesis.

These steps involve six different data sources, each being a small study in its own right. For comprehensive appreciation of the problems faced by HIV/AIDS-infected and affected persons, these multiple sources were deemed necessary for the purpose of this study. They form the focus of this Chapter. They are:

5.2.1.1   In-depth interviews with 5 members of an HIV/AIDS support group, focusing on the life world of people living with HIV/AIDS. (5.3.1).

5.2.1.2   Survey with a group of 100 church leaders and lay counsellors (at the time being trained by Siyahlanganisa Centre) providing a profile of the life world of the churches. (5.3.2).

5.2.1.3   Questionnaire interviews (including group construction of community profiles) with 50 church leaders and lay counsellors (at the time being trained by Siyahlanganisa Centre) based at churches in 5 different types of geographical areas in the greater Durban area, specifically focussing on the action field of family counselling practice in their churches, referral options and the need for further training of church counsellors. Information was also provided about community–based social service providers as identified by church leaders and lay-counsellors. (5.3.3).

5.2.1.4   Ten focus group interviews, with Church-based counsellors in different communities in Kwa-Zulu Natal, focussing on their counselling practice and the identification of dominant themes and discourses in their church communities. (5.3.4).

5.2.1.5   Three focus groups with church leaders in different communities in Kwa-Zulu Natal, focussing on their role as leaders related to the action field of their Churches in the communities and their interaction with the life world of people living with HIV/AIDS (5.3.5).

5.2.1.6   Questionnaire interviews with 36 church leaders (who have been trained by Siyahlanganisa centre) related to the outcome and impact of their training on their church communities (5.3.6).

The following table, as derived from Chapter two, summarises the overview of the mode of data collection and method of data analysis.

Table 5.1. Summary of Data Collection and Analysis Techniques.

Mode of Data Collection (In qualitative cases, enough data for theoretical saturation)	Method of Data Analysis
In-depth interviews. Face-to-face, non structured, individual interviews with support group members who are living with HIV/AIDS. Sampling method: purposive participative sampling. Transcribing of audiotapes. Semi structured group interview by means of body mapping workshop, with support group members who are living with HIV/AIDS Sampling method: purposive participative sampling. Transcribing of body maps	Qualitative: Narrative analysis and interpretation Qualitative: ABDCE Model Qualitative: Body Mapping Model
Survey with 100 course participants Sampling method: Non-probability, convenience sampling within the population of people who have been trained.	Quantitative: descriptive statistics . e.g. frequency distributions. Qualitative: synthesizing short answers and finding themes.
Questionnaire interviews (including construction of community profiles) with 50 church leaders and lay-counsellors based at churches in 5 different types of geographical areas in the greater Durban area. Sampling: Stratified, non-probability, convenience, snowballing within the population of people who have been trained.	Qualitative: Synthesizing short answers and finding themes.

Focus group interviews. Training of focus group interviewers. Transcribing of tapes Sampling methods: non-probability sampling, purposive participative and critical case sampling and snow ball sampling	Qualitative: immersion, understanding and interpretation: identifying themes and discourses
Questionnaire interviews with 36 church leaders (at the time being trained by Siyahlanganisa Centre) related to the outcome of their training.	Qualitative: synthesizing short answers and finding themes.

5.2.2 STEP THREE: DESIGN OF THE INTERVENTION RESEARCH MODEL AS ADOPTED FROM DE VOS (2001:385)

5.2.2.1 Discussion of research findings with HIV/AIDS support group (5.3.1)

5.2.2.2 Discussion of research findings with three church leaders and theological educators (5.3.2).

The developed data, from the initial field research and literature research were thus verified with people living with HIV/AIDS, church leaders and lay-counsellors, and theological educators.

The data were used to answer the initial research questions and specify and define what needs to be changed in the current scenario as per the Intervention Research Model (De Vos 2001: 385). These questions were:

- What is the nature of personal and relational problems facing a person living with HIV/AIDS, their families and their communities?

- What is the nature of services offered by pastoral counsellors to families with HIV/AIDS, and what are the effects thereof?

- What training model/programme can be designed in contextual and narrative family therapeutic counselling that will be useful for church leaders and lay counsellors?

The answers to these questions were used to justify the need for further training courses for pastoral family counsellors. Furthermore, the data was used to assess what should be included in these training courses, and how they should be designed.

In the view of developing training courses, examples of problems facing families living with HIV/AIDS were provided as case studies and translated in operational terms (use of contextual and narrative family therapy).

5.2.2.3   The observational system was designed to assess, e.g. the course participants' knowledge base, skills, quality of counselling, personal development and report writing.

5.2.2.4   Procedural elements of the intervention were specified, e.g. the need for training, working with gate keepers, planning, contextualizing of course material, marketing, implementation, evaluation and supervision.

5.2.3. STEP FOUR: EARLY DEVELOPMENT AND PILOT TESTING OF THE INTERVENTION RESEARCH MODEL AS ADOPTED FROM DE VOS (2001:385)

5.2.3.1   The prototype programme is developed. This part of the training development is concerned with the mode of delivery, selection criteria, selection and specification of intervention procedures (5.4.1).

5.2.3.2   The course is piloted in three different situations as per the need for different contexts to be considered (De Vos 2001) at a Bible College, at a local Church and at a Hospice (5.4.2).

5.2.3.3   The first pilot course: (5.4.2.1)

- Criteria and course information was specified with the Principal of the Bible College, who then recruited his students and hosted the course.
- A course content participant guide and Reader were developed to familiarize the course participants with the procedures.
- The pilot course was implemented at the Bible College, with a group of 10 students (co-researchers).

5.2.3.4   The second pilot course: (5.4.2.2).

- Criteria and course information was specified with the pastor heading the compassionate ministries of the local Church, who then recruited participants and hosted the course.
- A course programme outline and participant manual was developed, to provide the course participants with the course content and procedures
- The pilot test was implemented at a local Church with 2 groups of 15 participants (co-researchers) each.

5.2.3.5   The third pilot course: (5.4.2.3).

- Criteria and course information were specified with the director of the hospice and the pastor who is on the board, who then recruited participants and hosted the course.
- A course programme outline and participant manual was developed, to provide participants with the course content and procedures.
- The pilot test was implemented at a Conference Centre with a group of 25 participants (co-researchers).

5.2.3.6   Ongoing assessment of adequacy of the training programme was done by the researcher as well as course participants (co-researchers). (5.4.2.4).

5.2.4. STEP FIVE: EVALUATION AND ADVANCED DEVELOPMENT OF THE INTERVENTION RESEARCH MODEL AS ADOPTED FROM DE VOS (2001:385).

5.2.4.1   The experimental design was selected. This part of the training development demonstrates how the training impacts on participants and results in changed behaviour, both for the participants and their area of influence. (5.5.1).

5.2.4.2   Instructions and manuals were further developed, tested and revised. (5.5.2).

5.2.4.3   A supervisory system was developed to assess trainee competence, personal development and external accountability. (5.5.3).

5.2.5 STEP SIX: DISSEMINATION OF THE INTERVENTION RESEARCH MODEL AS ADOPTED FROM THE VOS (2001:385).

5.2.5.1   The training programme was given a name and possible funders selected. Unit Standards were assessed. A plan was designed to advertise the programme and a structure to organize ongoing training courses in family therapeutic counselling skills. (5.6.1).

5.3   RESEARCH FINDINGS

5.3.1 In-depth interviews with five members of an HIV/AIDS support group, focussing on the life world of a person living with HIV/AIDS.

Narratives of living with HIV/AIDS. This part of the study will explore the life narratives of five people who are part of a support group for HIV positive people that meets twice a month in Durban. The group originated ten years ago and was initially facilitated by the researcher.

Method

A qualitative research approach was used, consisting of multiple interviews in a narrative format with people who are HIV positive. The researcher used Lammott's formula for fiction writing, namely ABDCE as developed by Muller et al (2001).

Participants

An availability sample of five people was used. Participants were personally approached and recruited by the researcher. The criterion for selection was simply to be part of the support group. The length of each interview was approximately 2 hours.

Researcher

The researcher brings her own personal story into the narratives. She has walked a journey with the support group for over ten years and is therefore familiar with the participants and over the years has shared in their life stories. The research 'concern' on her mind is: "the problems people living with HIV/AIDS face and the resources already in place to deal with these, as well as the possible need for further resource development ". She is aware though that maybe this is not what is on the narrator's minds and therefore asks a more content-less question, which may not answer her initial concern, but at the same time will inform it.

Method of data gathering

In the process of gathering the narratives, only one question was used initially: How is it for you to be living with the HIV virus? Participants were informed beforehand that the researcher simply wanted the story of their lives, living with the virus, for research purposes. The interviews were audio taped and notes were taken for additional information, such as body language. Ethical concerns were respected and have been discussed in the chapter 2.

Analysis of data

The method of analysis was based on a 'categorical content' perspective (Lieblich et al 1998). The process involved four phases.

Firstly, on the basis of the research question, and unfolding information, the relevant material was identified and collated to form a 'subtext'.

Secondly, the 'subtext' was explored for content categories and placed in the ABDCE structure. In this process the interview questions played a role as well as the themes in the narratives. The themes become more detailed and find significance in the story as a whole. Attention was also given to the tone of voice and the body language of the story teller in relation to the themes. The researcher also took note of the narrator's surroundings and their interaction with their surrounding. All interviews were held at the narrator's homes. The process proved to be hermeneutic in that careful reading was followed by sorting the subtext into existing themes or finding new ones, with subsequent further reading and re-reading and gaining more understanding about the people involved and what it means to be living with HIV.

Thirdly, The ABDCE model guided the researcher to read the stories in a specific way. The social constructionist agenda is to describe, unpack and explore alternatives of a story; focussing on, in this order, Action, Background, Development, Climax and Ending. Conclusions were drawn with special emphasis being placed on contradictory textual elements.

Fourthly, the original narratives were re-read in conjunction with the researcher's conclusions and the question was constantly asked. Have I allowed the voices of these persons living with HIV to be heard? The conclusions were then presented and discussed with the narrators at a support group meeting, to which the other support group members became outsider witnesses.

Ethical considerations

Participants were assured that their personal identities would be protected at all times. In the writing up of the data this was ensured through the use of pseudonyms. Permission was obtained to tape the interviews and confidentiality was assured. Participants also gave their permission to submit the findings for research purposes.

The researcher will be deleting the recorded narratives after analysis and acceptance of this report.

Results and discussion

In order to present the research participants, pseudonyms are used and certain details are withheld in order to ensure confidentiality and anonymity.

Narrative one: Pseudo name-Lindiwe, female and HIV positive

Table 5.2. ABDCE Outline for interview with: Lindiwe.

| Action | Lindiwe wants to talk about churches, as that they should "stop demoralizing condoms" "They should encourage parents to teach their children about sex and sexuality" Also in the church people go to the support groups "so they can find out who is HIV and then the next thing they talk about them, there's no confidentiality at all at churches" "those are the things that churches should look closely at".… "Now I can say the virus doesn't scare me, but, uh…now that I'm on medication and then what if I…*become resistant? …*being HIV positive, not having a proper job, my family is not here…I'm relying on friends and all other people...whenever I need comfort"…

"Also having HIV I can say it was an eye opener, I started to take myself seriously… I realised I am, I can go on…I'm seeing myself in another perspective… I'm doing things I never could do before, I'm being able to reach out to other people… and lately I'm actually open about my status… people need to be taught about HIV/AIDS …I'm healthier than I was years back...I'm hand'ling things in a very different way...it builds me...it helps me...sometimes I go to other organiszations where I meet with other positive women and we discuss our issues".

You showed me a poem earlier on, where you talk about darkness, what you're telling me now sounds more like light shining in your situation. How do you explain that?

"First you have to accept that you are HIV …it took me like 2 years to accept my status...in most cases I was feeling like no matter how hard I'm trying to get out of this darkness, this pressure rising in me is trying to pull me down, so that I can't reach out... I try to do something positive, to move forward… there will be an obstacle or trial that's gonna come and block me to go forwards…that doesn't mean I'm gonna stop trying...to fight, you don't have to use the force, you can also use your heart and your brains" |
|---|---|

	"When I first found out that I was positive, I told a friend and she said 'so, what difference does it make? Are you a different person? I was amazed. She's been there and many more others. My family have known a long time, they are ok with it."
Background	**Lindiwe has been very ill and the doctors told her to go home and wait to die, she decided to fight back and asked "I just want to know, who created me, a doctor, a nurse, who's got power over me…I am God's creation" She then managed to get the right treatment and recovered…Since she's shown initiative in life, but things don't always work out for her...**
Development	***"So, how do you see God? What image do you have of God?"*** **"I don't really know, I think I can relate to God as anything and everything…and then when I was told to go and die I asked Him a question and then He answered me immediately…if God doesn't send you any tests in your life, you're not going to be strong..."**
Climax	**Lindiwe had some very sad experiences in her life and finds it hard to trust. She shares a story about a supportive friend and she is also seeing someone that she has learned to trust...when her brother got married, his wife treated Lindiwe very well….**
Ending	**…"okay it can rain for a few days or even snow, and create some dangerous situations, but somehow it's gonna stop and then the sun will shine again. Another thing…there's no such thing as living in the past or okay, healing wounds, they don't actually heal…they shrink, they look like a little creak...you can't see, or you forget about it for some time, but they are wounds still...but now I'm just me you know...I have to move on"...**

The following themes and discourses came to the fore :

- The churches' responsibility and Lindiwe's determination to point them out. Lindiwe has become disappointed with the Church and used the metaphor of 'safe house'. Her experience has been that Churches are often not safe, as church goers gossip, judge and are not living pure lives.

- Lindiwe's experience of being HIV positive. She expressed the importance of accepting the status, living a healthy life style, meeting with other infected people, and openly speaking about being HIV positive.

- Acceptance of HIV status and 'becoming open' Lindiwe explained that this is a life changing process, both for her as for those she's in contact with.

- Living with adversity, the reality of scars and always keeping hope. Lindiwe's family of origin lives in a rural setting and there are myths believed about HIV infection. She is impressed that the family listens to her and not to the voices outside. Lindiwe is coming to terms with the adversity in her personal life.

- Discourse of victimized HIV positive patient and her reaching for the highest authority. Lindiwe realised that God has the say in her life and used that 'revelation' both as an inner resource as well as a 'force' to have the courage to stand up for her rights as an HIV positive patient.

The challenges regarding culture and myths, justice systems, morality and religion that Lindiwe referred to, were also described by Kanyoro (2003).

Narrative two: Pseudo name-Dion, male and HIV positive

Table 5.3. ABDCE Outline for interview with: Dion.

Action	Dion comes straight out with what's on his chest. Disagreement with his brothers, his friends not inviting him around, his partner away for 5 weeks, his granny becoming bedridden and in need of care… A few weeks later, his granny passed away and he was diagnosed with TB, which also may have influenced his state of mind. "I just wanted to get away from here" "I think to myself I'm alone… the only place that I went to was group and back". "I was going to be put on medication. I just feel that I don't want to get onto that anymore because I honestly don't want to live anymore, I'm just tired of all this, also because I don't serve the community, I don't do anything"… "You know I started gardening and taking care, but then I started neglecting it, if you're not appreciated for it"…
Background	Dion internalizes what is said to him in anger and blames himself for how he perceives others see him and therefore neglect or reject him. " His past also rings through…He grew up with a not agreeable father and his mother passed away when he was small.
Development	". "Gosh, anything positive about myself, most of my life has been so negative"… "*you're actually quite a nice person, you've just proven it"…* the conversation turns towards more positive info about Dion's brothers…

179

	admits that he's done some gardening and accepts the compliment explaining how much work went in it... also affirms that he takes proper care of his granny and is concerned about her hardly taking some food. "I suppose I'd like to start up my business again, to start making some money, well my machines are in the garage and I haven't been there… I said I was starting a business, that was a year ago… and it just goes on..."
Climax	"So I hope this is of use, because I said I stopped visiting my friends because I just always complained about stuff. It's always the negative and there's no like good news! "*If that's what you need, you're welcome to just come and complain*" He laughs and says ok and that it's just nice to record things, "because sometimes you know, you don't realize what you say and, um, ya"
Ending	*"It's going to be used to find out how people are relating to their status, and what needs there are in their lives, and those are not just related to that part of their life… that's basically what you've given me here…"* "Okay!"

The following themes and discourses came to the fore :

- Lack of positive feedback at home for who he is and not comfortable to disclose his HIV status to his family. Dion's contribution to the running of the family home is taken for granted and not validated. Disclosing his HIV-status might put him at risk to a further undermining of his integrity, and his position in the family.

- Perpetuating feelings of loneliness, with risk of neglect of his health. Dion presents with a depressed mood, as he experiences an imbalance in the 'give and take' of life and is lacking a conducive environment that supports him to live a healthy life style and reduce the influence of the HIV-virus in his life.

- Discourse of homophobic environment in family of origin. Dion grew up with a domineering father, who expected boys to behave in a culturally defined way. Dion's liking art and craft, beauty and social justice were unacceptable and therefore ridiculed by his dad, who would call him names related to feminine homosexual behaviour.

Similar barriers for gay men in receiving support from their families of origin were discussed by Kadushin (1999).

Narrative three: Pseudo name -Leroid, male and HIV positive

Table 5.4. ABDCE Outline for interview with: Leroid.

Action	When diagnosed medical doctor cried, as Leroid accepted his result calmly like a death sentence. Took early retirement. "It takes a while to learn that you're not the professional person anymore, you are just nobody, you're just you, on your own and then you've got to cope with that..." "I was a very outgoing person, who was very well known…" "I'm happy in my home, my garden, my friends, I used to be someone who would go to parties, but if u can't drink and stuff..." "*how did you envisage not working anymore? …*" "before or after the virus?..." "when you're tired your body will tell you... a good indicator…"
Background	As a teacher always giving, providing... in gay community in early years friends got AIDS and disappeared… caused fear... grew up in dysfunctional home... attracted people that needed help or guidance... often alcohol related…
Development	"I don't feel driven anymore... if you're asking what I'd like to do? Something in the HIV/AIDS... I think I'm a good communicator... I think I have a great strength there in interacting with people... I want to find my creativity again... otherwise I could sit here and think I'm a victim... I need to develop myself…"
Climax	"I think the best thing to do would be to stimulate thinking and say look, this is my experience, this is where I come from, this hits everybody, that I was a respected professional person and I got it, you know and I was careful too…"
Ending	"What I would love, I would love to be still useful…I should go and visit the school across the road..."

The following themes and discourses came to the fore:

- Theme of wanting to make a difference in the lives of (young) people. The expressed need to contribute to and protect the next generation from harm.
- Discourse of dominant story of living with the virus as a medicalized condition, where the virus becomes the deciding factor for life choices and the medical profession's inadequacy when responding to HIV positive people in the past. Associated theme was that through a process of disclosure, friendship support, and acceptance, the realisation of the possibility of a renewed vocation can add meaning to the life of others.
- Theme of disclosure. Leroid disclosed to his family, as he felt prompted to tell them straight-a-way, though his mother was very upset. Process of disclosure with friends: 'Who talks first' and past experience with friends that had died or did not disclose. Non-disclosure at work, as already his sexual orientation caused discussion about his work performance.

Leroid's story affirms Elizur's (2001) notion that families may shift from initial crisis of disclosure to family acceptance, as well as the vitality of peer support.

- **Narratives four and five: Pseudo names-Paul and Helen**

Table 5.5. ABDCE Outline for interview with: Paul and Helen.

Action	Couple found out their HIV status through pregnancy, miscarriage at 6 months. Paul talks about the ease with which he can tell 'strangers' that he is positive. "my problem is the people that I know, my family that I'm close to". "In other instances they'll be the first people to tell". Helen: the pregnancy was actually the thing that saved us, at the time Paul was so sick, I think we would have really lost him, if we would have found out then.
Background	Paul grew up in environment with drug abuse all around him… "10 years old I was already smoking mandrax tablets with my uncles, at my mother's house if you wanna smoke zole, it's ok, don't go on the streets, don't go to the police" "I'm not from a close knit family, my mom and dad didn't get married"
Development	"I just wanted to tell my god mother, she's my closest, she knew I was sick,

	I had shingles, TB, I've lost weight-there's something up with the guy, she knows it's terminal as well, but she'll never ever ask- it's something that you have to come out with. When I met Helen all of a sudden I softened up... I saw like family life, from now on, her son, this family orientation"… Helen: "my children don't know and we've never really gotten to the point where we ever felt we were ready to sit them down and tell them". "The doctor said if I were you, I'd think of my health, and I said oh, ok … the new doctor says Helen, whatever you want you must go for it"..
Climax	Paul: "I feel that I've been given a whole lease on life again. God will take you, if He loves you He will bring you to a point where he talks to you. He's chastised me, like Job,.. the devil said I came across this Job and ei man, he's like so into you, you've got this big fence around him, I can't get in there… God say ya, I've got faith in my son Job"… *it's important for you to feel that God has faith in you...* "Absolutely, God has faith in me, God allowed"… Helen: "I know there are no guarantees but I know I can carry that baby the whole time, the baby is gonna be borne fine, protected and comforted".
Ending	The couple is left with non-disclosure to their families, substance abuse that has taken a back burner, Paul came to believe that God allowed him become poor, that he lost his child and his health in order for God to test his faith. Helen is grieving her lost pregnancy and determined to have a family with Paul.

The following themes and discourses came to the fore:

- Non disclosure to the family. The difficulty of disclosure to a dysfunctional family, as they are 'enmeshed' and 'unstable'. Paul considers disclosure to the most mature member in the family, who has expressed concern for him.
- Discourse of pregnancy and new life, making all well. The pregnancy was perceived as the 'saving factor' for Paul's diagnosis and treatment, the stability and future of their relationship and Helen's main focus and identity in life.
- Discourse of God as judge, who gives and takes away. The bad things that happen in life are there for the purpose of testing our faith in God's knowledge, authority and love for us. Paul's hope is in the exercising of faith in God, which in return would restore to him what was taken away.

Paul and Helen did partake in the body mapping workshop as mentioned in Chapter Two. The outcome of their "maps' was that Paul wants a future with Helen, but is afraid to be hurt, is afraid of real love. His statement: "the reaper comes for all of us" seems consistent with his expectation of God's punishment. Helen gave her children the central place in her map and said they give her energy to go on in life. Her best memory was having her babies.

Louw's (2006) description of a theology of resurrected hope, where people are assessed from the viewpoint of constructive and realistic affirmation, and validation of their identity and dignity would have provided a more conducive paradigm for Paul and Helen to re-write their life narratives and find acceptance and healing.

Findings of the study:

The five narratives created the awareness that living with HIV/AIDS is interwoven with life's challenges. In relation to the study at hand, the researcher realized how welcoming the participants had been and valued an open ear to their life experiences. The themes of disclosure, homophobia, 'the making of meaning' and the need for affirmation seemed prominent in the stories. Family counselling may offer a relevant and strength based intervention for participants in dealing with issues of disclosure, losses and trauma. However, structural issues of concern that sustain these concerns should not be overlooked in a training programme. For the development of the training programme, the researcher realized the strength of the ABDCE model and will seek to incorporate this model in the case presentations of the participants.

5.3.2. **The following study is aimed to provide a 'state of the art review' of the life of the Churches in the greater Durban area.**

A survey was done with 100 course attendants (church leaders and lay-counsellors at the time of being trained by Siyahlanganisa Centre) providing a profile of the life world of the local churches.

The Study

Research was conducted in 2004-2005 in the greater Durban area, with participants in HIV/AIDS training for churches. This causes some bias in the findings in that they reflect data only on the churches of people who attended the training, and thus are already in some way active with regards to HIV/AIDS. The participants came from a wide selection of churches, including The African Pentecostal Church, Anglican Church, Apostolic Church of Christ, Apostolic Church of South Africa, Apostolic Faith Mission, Assemblies of God, Baptist Church, Christian Centres, Church of God of Prophet, Church of the Nazarene, Ethiopian Church of South Africa, Ethiopian Combination Church, Ethiopian Congregational Church of South Africa, Evangelical Church, Evangelical Lutheran Church, Fellowship Centre, Full Gospel/Pentecostal Church, Holiness Union, Holy Apostolic Church, Jehovah's Witnesses, Korinate Church in Zion, Light Holy Church in Zion, Living Waters Family Church, Living Well Ministry, Lutheran Church, Methodist Church, Nazareth Baptist Church, New Season Church, New Zion Apostolic Church, Oasis Fellowship Centre, Old Apostolic Church, Pentecostal Baptist Church, People's Church, Power of God Assembly, Revival Fellowship Church, Roman Catholic Church, Salvation Army, St. Andrews Church, Twelve Apostles in Christ Church, United Congregational Church, Uganda Parish, Voice Light Apostolic Church of Christ and The Zionist Church.

The following table represents the sample.

Figure 5.1. Distribution of Church denominations of participants in the survey.
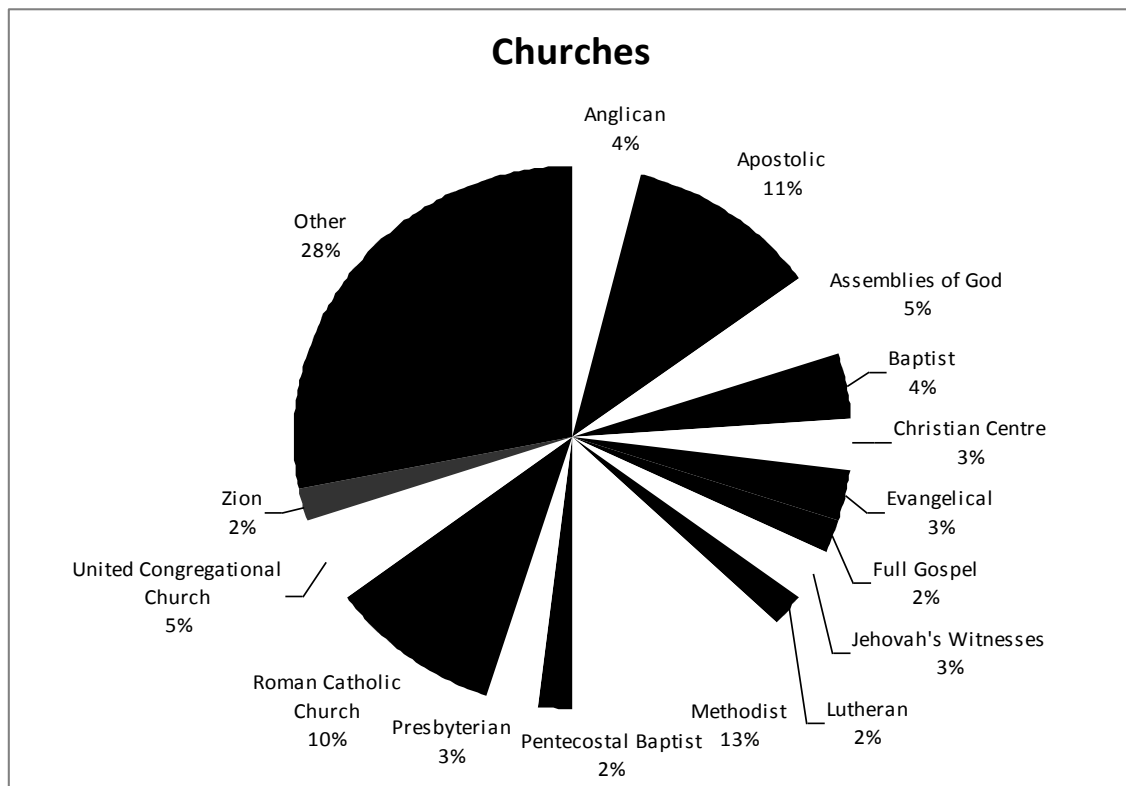
The research was comprised of a questionnaire including both quantitative and qualitative questions. Non-probability, convenience sampling was done within the population of people who had been trained. A group of 100 participants was used.

Findings

5.3.2.1 HIV/AIDS Care/Support Teams

In the sample of 100 participants, 49% said that their churches had an HIV/AIDS Care Team, 48% said that their church did not, and 3% did not answer the question. In the churches where there was no Care Team, 45.8% did have someone to coordinate HIV/AIDS work, 39.6% did not, and 14.6% of the participants did not answer this question.

Figure 5.2. Do the participants' churches have an HIV care team, or someone to coordinate HIV/AIDS work?
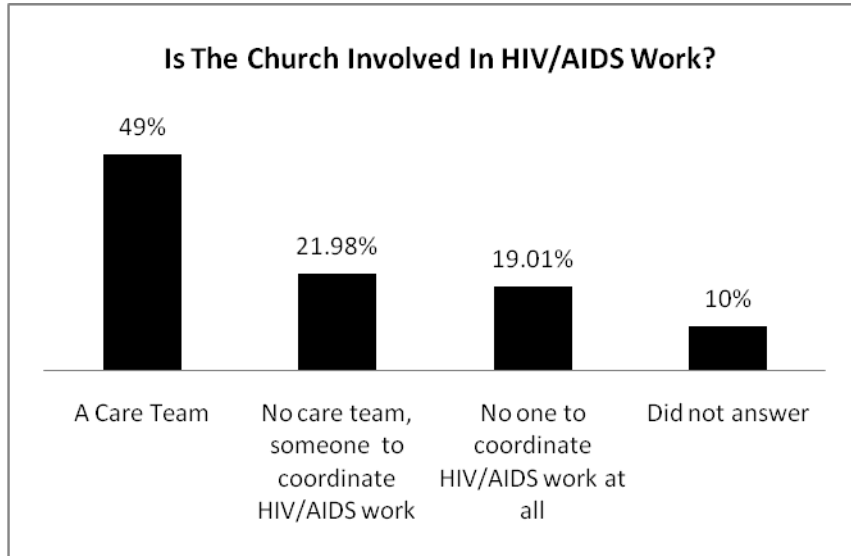
5.3.2.2   Providing Congregants with Information About HIV/AIDS

In the sample of 100 participants, 80% said that their churches provided information to members about HIV/AIDS, 17% said they did not, and 3% did not answer. Of these, 54.9% provided written information, 69.5% provided individual counselling on HIV/AIDS, and 85.4% of participants' churches organize information meetings for church groups (here 2 participants did not answer). This is similar to the findings of Parry (2005) who described information provision as part of most denominational policy statements.

Figure 5.3. Methods churches use to provide information about HIV/AIDS to their members.
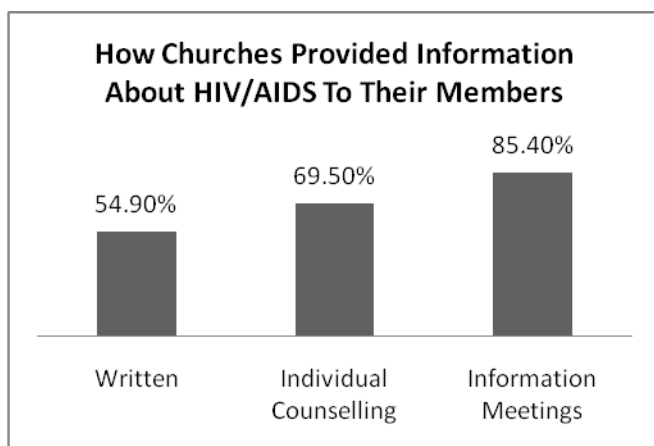
The 17% who said that their churches did not provide information to their congregants about HIV/AIDS were asked the reasons for this; these included the following: not prioritizing, leaders lacking information, a lack of cooperation, direction or involvement, a lack of opportunity, a lack of equipment or a place to give such information, the church going through a transition in leadership, and the fact that people do not wish to talk about HIV/AIDS. This is a similar to findings of UNAIDS 2008.

The researcher finds it encouraging that so many participants are aware of and partake in what their churches are doing relating to information and education. It also shows insight that participants are aware why their churches are not so involved. For care teams and community education to be optimally effective, attention will need to be given to the training of the church leadership, in order to become informed about HIV/AIDS, to mainstream HIV/AIDS and network with other (faith based) NGO's, as discussed by Parry (2005).

5.2.2.3   Spiritual Support for HIV positive people from Churches

In the sample of 100 participants, 81% participants' churches provided spiritual support to HIV positive people, 12% did not, and 7% of participants did not answer. Participants were also asked what type of spiritual support was given; this included: visitation (sometimes daily, to homes, hospitals and hospices), prayer (including prayer groups and prayer from the church), counselling (including referral counselling and counselling

at centres – e.g. The Dream Centre), support, encouragement, reassurance, love, comfort, sharing scriptures and God's love and hope (including to tell people that HIV/AIDS is not a punishment from God) and support groups. When asked why spiritual support was not provided for HIV-positive people, participants said that people have not disclosed their status and do not want to talk about their illness.

The researcher finds it encouraging to see that home visitation work includes those that are HIV positive and that so many of the participants are aware of their churches work. In many home based care settings, people that have not disclosed their status, would still be looked after and receive spiritual support, as the focus is on their presenting condition. The strength and community presence of faith based organisations is also mentioned by Larson (2008).

5.3.2.4 Help for HIV positive people from Churches

The group of 100 participants were asked whether their churches had ever helped someone to find their HIV-status, find their CD-4 count, apply for antiretroviral treatment or apply for grants and benefits, referred someone to Income Generating Projects or supported someone in taking ARVs. The following results were found:

Figure 5.4. Involvement of Churches in HIV-Care.
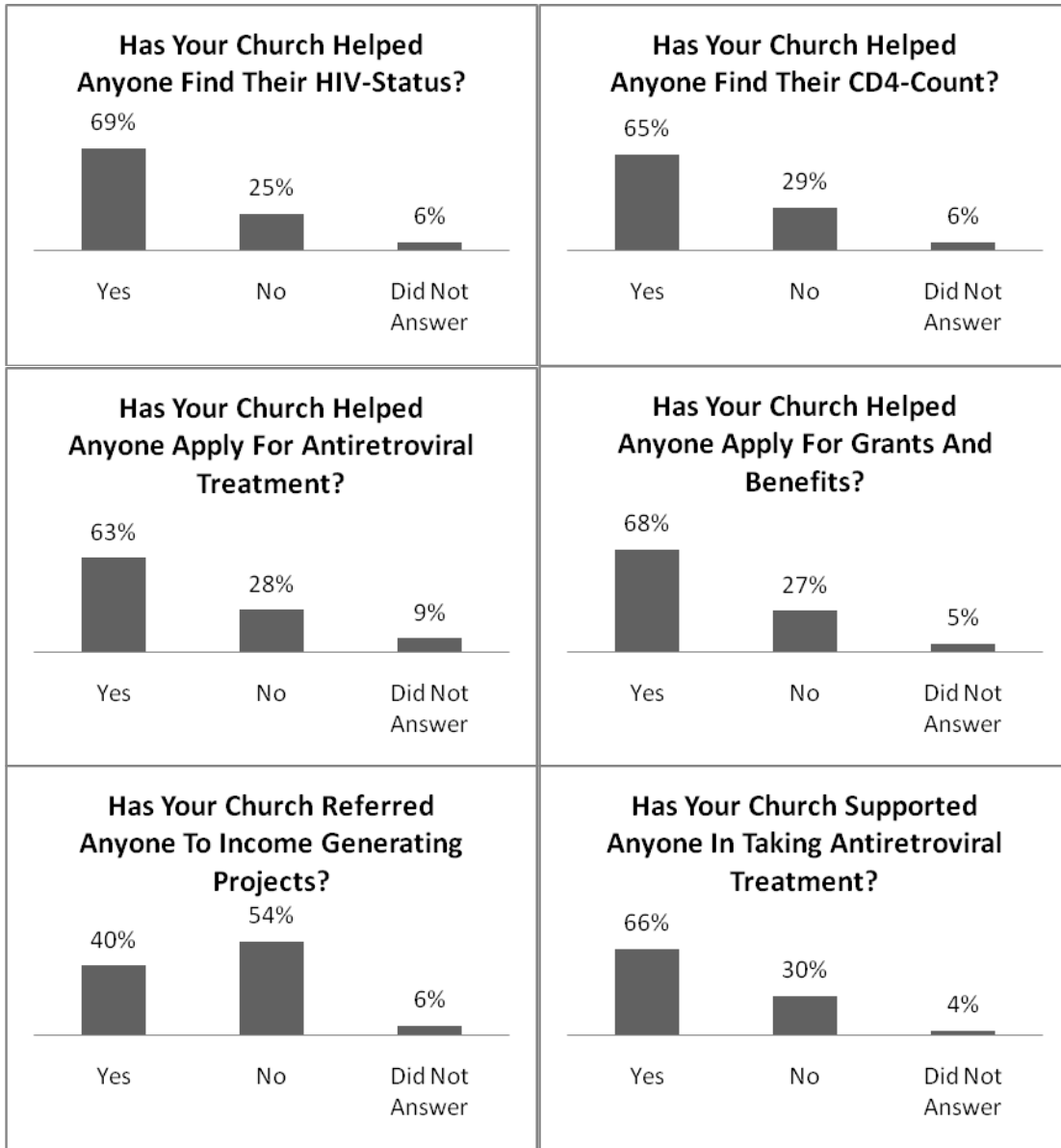
Furthermore, the study looked into how much involvement churches had at all in the abovementioned activities, that is, the lives of their church members in relation to HIV/AIDS: Of the 100 participants included in the study, 54% said that their Churches did a lot (5-7 of the above activities), 22% said their churches did a moderate amount

(2-4), and 20% indicated that their churches did little (0-1), 4% did not answer the questionnaire entirely. 26% of churches were involved in all the above activities, and denominations to stand out in this were the Methodist Church, the Roman Catholic Church and the Charismatic Christian Centres.

From the 'state of the art' as researched by Parry (2005), as well as from their own research documents, the mainstream churches are often well structured and can manage much outreach work.

5.3.2.5   Churches, children and HIV

Of the sample of 100 participants, 79% had a youth ministry in their church, 10% did not, and 11% did not answer the question. Of the churches with a youth ministry, 46.8% had youth leaders who had received HIV/AIDS training, 45.6% did not, and 7.6% did not know whether the youth leaders in their church had received training on HIV/AIDS. Of the churches that did not have a youth ministry, 2 of the 10 had leaders had received training on HIV/AIDS.

Of the entire sample, 32% had a program for HIV-positive children, 41% did not, and 27% did not answer the question.

Figure 5.5. Churches, HIV and Children.
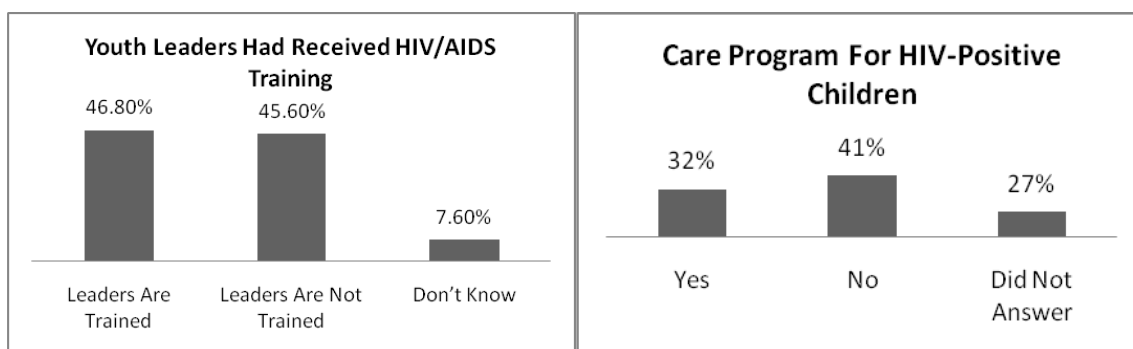
Participants were also asked what type of Care Programs they had in place for HIV-positive children; these were: donations (food – sometimes a food parcel or feeding

scheme, clothes and toys), health care (including kits, taking the children to the clinic and care givers), education (including paying school fees, and buying stationary and uniforms) , homes, safe nests, visits, love, prayer, teaching children about HIV/AIDS, abstinence, showing video tapes on the subject, referrals to counsellors, helping children to access grants, and a support group. (Note that they do not mention themselves as counsellors). The Care Programs in place for orphans included; donations (food and clothes), homes, foster care (or finding someone who is prepared to take care of the children), places of safety, visitation of homes to find needs, motivation, education (funds, stationary), training program, referral to social welfare, help to access grants and assistance with financial problems. The variety of services mentioned are deemed necessary in the light of the risks that orphaned and vulnerable children are exposed to, as listed by Williamson (2000).

It is encouraging to see that youth leaders have been trained in HIV/AIDS and do communicate the information to their youth groups. Richter (2004) too emphasized the importance of VOC's relationships with caring adults. The extent of care that is provided by the Churches would also warrant the development of training in child psychosocial and family counselling. The antiretroviral treatment support is not mentioned by the participants.

5.3.2.6   HIV/AIDS related counselling in Churches

The topics discussed in pastoral counselling sessions were varied and included: discovering ones' status and dealing with the confusion, hopelessness and depression experienced if it is a positive result, issues of disclosure, stigma, rejection, dealing with different attitudes, parental support, family members of infected people and discrimination at home. Unwillingness of other people to talk about HIV/AIDS, loneliness, suicidal feelings, health issues such as taking medication, living with HIV, youth that are sick, grandmothers who have lost daughters, orphans and old age carers. Also: poverty, unemployment (some people mentioned not having the money to go to

hospital), lack of food, ways and means to get grants, emotional and financial issues, trauma, stress, peer pressure, smoking, alcohol and drug abuse, overdoses, dysfunctional families, incest, domestic violence (including women and child abuse), marriage, divorce, adultery, and rape.

About half the churches provided counselling at another venue. This counselling is provided at people's homes (door to door, sometimes to refugees), in the community, clinics, hospitals, prisons, police stations, colleges, mental health institutions, and at organizations such as The Dream Centre, which is a step-down service and was closed down in 2008.

Topics discussed, which are different from the above mentioned are: fear about the future of children and spouses and finding homes for the children; anger and blame in couples and youth who have lost their babies; dealing with overwhelming emotions, helplessness, isolation and people who have no one to look after them; financial problems, referrals, treatment not being provided and organisations not treating people who are sexually abused without the case number; questions regarding HIV, legal matters and health and people who believe in witch doctors. 20% of participants did not know of any pastoral counselling whatsoever at their churches.

The researcher realised that home visits and supportive care and counselling services may not sufficiently address the list of complicated problems presented. This was also evident from the narrative described by Magona (2004). The participants are well aware of what goes on in their communities. They mentioned the provision of voluntary counselling services through the church at several institutions in the communities.
The researcher recognises the need for comprehensive counselling training: e.g. crisis counsellors who provide services to local police stations, family counselling training that focuses on bereavement, psychosocial problems and relationship counselling. With all these counselling requests, a good system of coordination is very important. In addition, impoverished circumstances and contexts need to be acknowledged and services offered within these restrictive environments.

5.3.2.7   Support Groups in Churches and communities

The sample of 100 participants was asked whether their churches had a support group or not. 53% said that they did, 42% said they did not, 2% said that their churches were in the process of starting a support group, while 3% did not answer this question.

In 62.3% of support groups members were said to disclose their status; in 13.2% they did not and in 18.9% of support groups only some or a few of the members disclosed their status. 5.6% of those participants who said that there were support groups in their church or community, did not answer this question, presumably because they realized this an area that was yet to be addressed, and did not want to specifically expose this neglect. Within the denominations: The Roman Catholic Church, The United Congregational Church and The Methodist Church, the proportion of churches that have a support group was higher than the norm. Support group meetings were generally held in community halls, clinics, church halls or in organisations such as Diakonia or MEDSA. They were, however, also reported to have been held in school halls, social clubs, sports centres, child welfare establishments, peoples' homes, and even in a mobile unit in informal settlements.

Unfortunately, in this survey the nature of the support groups were not investigated. Most community based support groups are of an income generating nature, addressing the context of poverty and unemployment. Often participants do not stay in the same area as where the group is held. There is still much stigma attached to being part of such a group. The researcher hopes that as part of the family counselling project, more Churches will provide support groups on their premises, addressing the twin problems of stigma and poverty as discussed by Kasiram (2009).

5.2.2.8   Mental health or Psychosocial problems

Participants were asked to comment on the main mental health or psychosocial problems in their churches. These included alcohol and drugs, domestic abuse, crisis

pregnancy, HIV/AIDS (spread, sickness, infection, stigma, accepting that some members in the church are HIV-positive), other STDs, poverty and unemployment, crime (including violence, impact and incarceration),orphans living below the poverty line, abandonment, desertion, grief, family relationship problems, widows, divorce, teenage rebellion, depression, suicide, sexual abuse and survivors of child sexual abuse. A few participants, however, indicated that their churches did not deal with many mental health issues; their reasons were that there are no or few such problems in their churches, that the church simply did not deal with these problems, and one participant said that the people in his/her church were only interested in getting their own grants and not interested in other people's problems.

The researcher agrees that mental health problems are often denied in families and communities. Seeing the list of acknowledged problems also means that these problems are known to exist, with the training programme needing to provide more information and skills development to meaningfully address them.

Then, participants were asked what services were available in churches to help people deal with these problems. Out of the 100 participants asked, 32.9% said that their churches provided some kind of services, 35.7% said they did not, and 31.4% participants did not answer the question. Services included (crisis) counselling, referrals, safety services (such as committees to do patrols in communities on weekends), help with issues related to HIV/AIDS (also food parcels, clothes, medicine), a divorced women's support group.

Figure 5.6. Services Available in churches to help people deal with mental health/psychosocial problems.
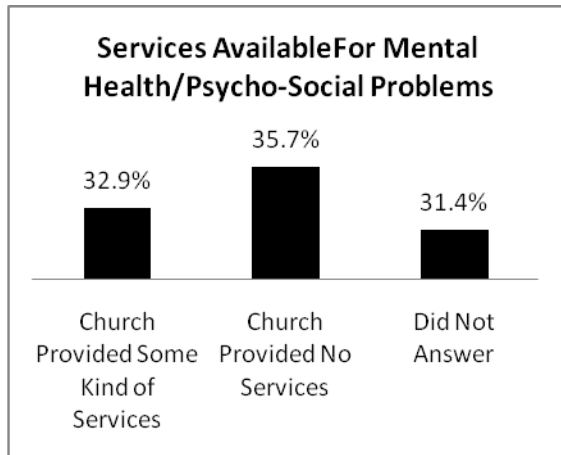
The above information shows that there are definite service gaps in the church communities, which need to be addressed in the content of the training courses. Family counselling incorporates preventative work, specifically related to issues such as teenage pregnancy and substance abuse. To address the contextual difficulties such as poverty, pastoral family counsellors would also need to connect with other community based organisations who are involved with income generating projects and skills training, as discussed by Gueyer (2006).

5.2.2.9 HIV/AIDS in the Churches

Participants were asked about the response to HIV/AIDS in their churches. Firstly, in the sample of 100 participants the following results were found:

Figure 5.7. The Response of Churches to HIV.
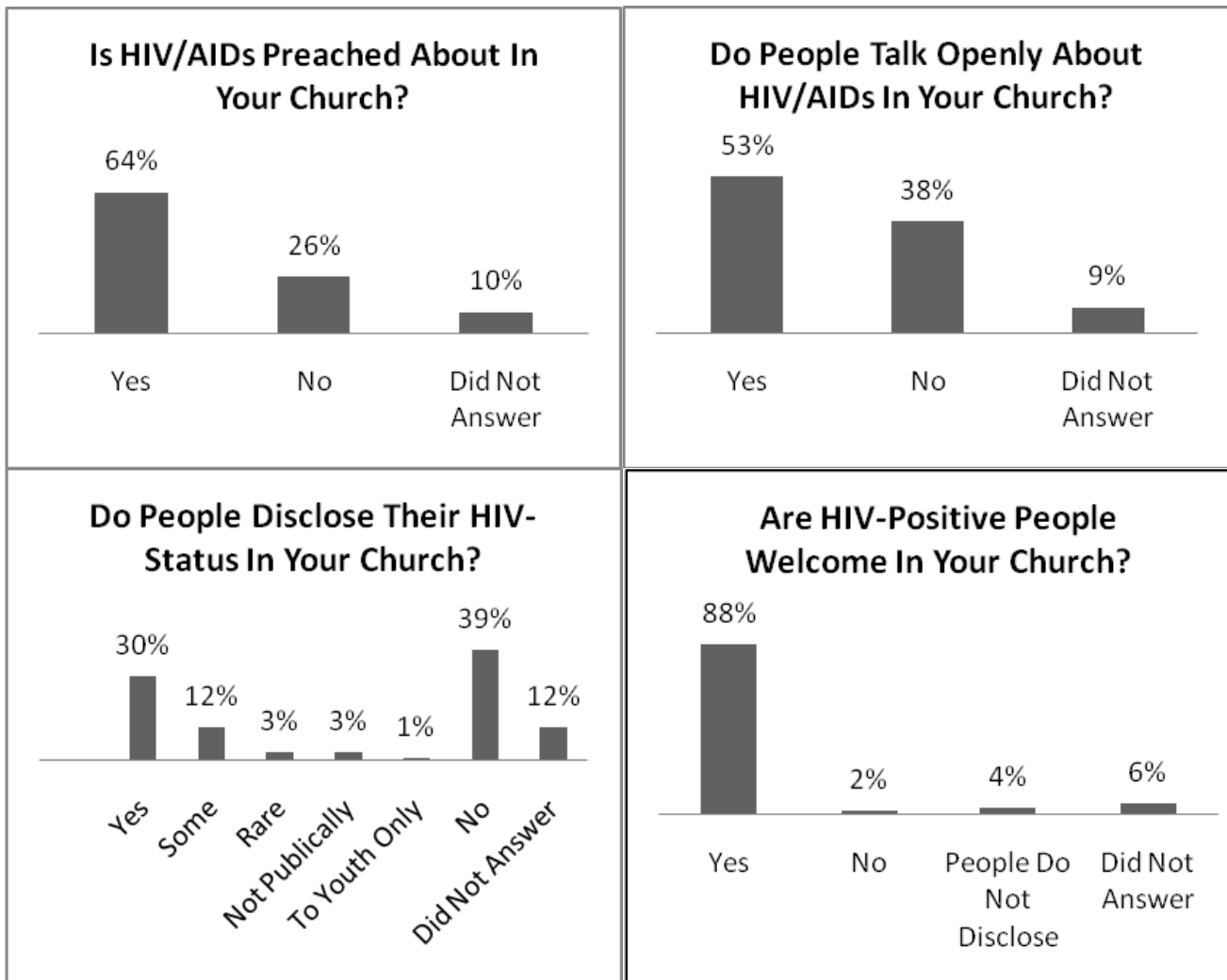
Participants were also asked to express how HIV/AIDS training had been meaningful to the church. Their replies were that training develops understanding, in the church of infected people, and in the infected people themselves and understanding of their own condition. The church members are more willing to help, they have learnt how to help, and they also have more respect for those who are infected, express more love, support and encouragement. This makes infected people experience more freedom in the church, and more people are willing to disclose their status as a result. One participant explained this saying: "we are combined together to help the community and church".

The participants also said that training creates awareness and interest within the church, pastors have begun to preach about it, and this stimulates conversation, people are not scared to approach the pastor, or each other, with this problem. There is also information sharing, people pass on the knowledge they have learnt, and educate other members. Only one participant thought that training had not helped his/her church at all, but did not provide a reason.

The researcher realised that there still exists a high percentage of non disclosure despite openness that the pastors and counsellors try to encourage. The focus groups mentioned a similar dynamic, that people did not want to receive counselling because they did not wish to disclose their status in the first place. Contextual and social stigma are also mentioned by Paterson (2005).

Participants were asked how their churches supported church members and their leaders in the activities they are involved in, and also whether they would like more help, and in what form. Of the 70 participants, 51.4% said their church supported them in some way, 7.2% said they did not at all, and 41.4% were not filled in, but for some of these one could assume that no help was given, as the questionnaire did not ask this specifically. Of those participants whose churches did support their members, 82.4% would like more support than they are getting.

Types of support given to members at this stage include monetary support and giving of goods needed – fundraising, buying and announcing in church the needs of members, providing accommodation at cheap rent prices, food parcel ministries, donations (e.g. for projects, building) and allowing the use of resources; reaching out (e.g. asking how projects are going), encouragement, support and acceptance, visitations – cleaning washing, bringing food, giving a hand where necessary, support, follow ups and referrals; singing gospel, playing soccer, coming together as volunteers to report on problems, helping with planning, prayer meetings, social action program, hospice and hospital visits, prison work and helping sister churches.

In terms of support, participants have indicated they would also like: to have an HIV/AIDS team/committee and/or a full-time pastor/minister dealing with HIV/AIDS or to train the current church leader, to have a church policy on HIV/AIDS in place, to create an HIV/AIDS helpdesk and/or more services allocated to HIV/AIDS; to have a support group and group discussions and talks about issues surrounding HIV/AIDS, to have training, workshops and sermons/talks in church to teach people about HIV/AIDS, and meetings with the youth to teach and discuss HIV/AIDS. Participants also indicated the need to have more projects to help people infected and affected by HIV/AIDS - fundraising, donations, soup kitchens, food parcels, income generating projects, visitation of the sick and to help them physically and spiritually, help for children, orphans and the poor, full support of families, financially, spiritually and emotionally; HIV/AIDS workers would also like to be supported financially, spiritually and emotionally, and would like to see members of the church working together and getting involved, becoming part of the support, and they would like to be supported themselves when they come forward to help those who are infected.

In summary, the life world of the represented Churches is saturated with the problems that are needed to be addressed in a preventative, counselling and supportive manner, and are also discussed by Parry (2005). Psychosocial problems are identified, but specific counselling services are often not in place, hence the need for more specific training and also affordable and accessible referral options. The Churches are actively dealing with the reality of the life world of families living with HIV/AIDS as well as with the most vulnerable households of child headed households. Physical support is part and parcel of spiritual and counselling support and could receive attention via existing structures that need to then cohere and network with the proposed training programme. Furthermore, before counselling services can be effective, the reality of stigma and discrimination, specifically related to psychosocial problems in the community and the cultural and gender based obstacles will need to be dealt with.

5.3.3 The following study is aimed to provide a 'state of the art review' of the counselling practice of the Churches in the greater Durban area

Questionnaire interviews were conducted (including group construction of community profiles) with 50 church leaders and lay-counsellors (at the time being trained by Siyahlanganisa Centre) based at churches in 5 different types of geographical areas in the greater Durban area.

The Study

This study was done using non-probability convenience sampling methods; the participants were all attending an advanced HIV/AIDS community counselling training course. This may have lead to a bias in results in that the churches mentioned do not include those who have not sent anyone to this specific, if any, HIV/AIDS course. Also, a stratified sampling technique was used with regards to area – ten participants were included from each of five given area types. These area types are: Suburb (Specifically: Wentworth, Sparks Estate, Glenwood, Verulam, and Newlands West. This area type also includes one participant from the Community of Refugees from the Great Lakes Region of Central Africa in Durban), Township (Umlazi), Semi-Urban/Informal (Pinetown South, Amoati, Amawoti, Cato Manor, Clermont, KwaDabeka and The Buffer Strip), Semi-Rural (Isipingo, Folweni, KwaNdengezi, Adams Mission, Umkomaas), and Rural Area (Ndwedwe, Mpumalanga (GMA), KwaNyuswa, Kwaximba, Embo Reserve).

Findings

Key questions were asked of the participants. The questions and their responses are presented hereunder.

Question One:

Do people consider counselling services to be an essential part of the ministry of their church? Why?

Across areas, a counselling service was considered an essential part of church ministry.

Suburb: the participants focused on a need for (qualified, well-trained) counsellors to establish needs people have (psychological, emotional) and to support people and show them love and encouragement, and privacy. Also, a lack of counselling facilities is seen to be a factor in the increase of crime and drug use rates.

Township: The participants focused on a lack of knowledge and awareness within the church, and also on the need for and scarcity of counsellors.

Semi-Urban/Informal: participants focused on the fact that counselling is the ideal place to educate people about HIV/AIDS, but also to bring hope, care, companionship, and love (also to people with other sicknesses), and for people to be able to disclose their HIV/AIDS status. Family counselling was thought to be important as families come together and can show support for each other and comfort each other.

Semi-Rural: participants focused on the fact that HIV/AIDS and other problems affect many people in the church and trained counsellors are better equipped to deal with these. Counselling educates people, gives them hope and empowers them; it also gives youth a place to speak openly and freely to informed people.

Rural Area: Participants focused on the fact that counselling can help with both family and community problems, as well as being a platform to share God's love and support and help people. Counselling can be used to spread awareness and combat the shortage of knowledge about HIV/AIDS.

The researcher finds it encouraging that mention is made of doing a needs assessment and the need for a professional approach to counselling. This is also discussed by Magezi (2008). The training and supervision of church leaders and the provision of a local counselling facility will fulfil that need, as mentioned by Klein (2009).

Question Two

Do Churches provide counselling to members only, or also to non-members? Why?

Suburb: All (but one) participant's churches provided counselling to both members and non-members; because the church should share God's love, and because many people, even non-church goers, prefer to go to a church for counselling.

Township: Two participants said that their churches provide no counselling at all and one only to members out of lack of time; but the majority to members as well as non-members. Non-members are also part of the community and counselling presents an opportunity to speak to non-members about life and Jesus Christ.

Semi-Urban/Informal: Who counselling is offered to differs widely from church to church. Some churches provide counselling to all people, out of the belief that God wants it like that; some to members only, because it is easier to talk about problems within the church, or out of a lack of facilities; and some churches provide no counselling at all also due to a lack of counsellors or because "people do not talk about HIV".

Semi-Rural: Most churches provide counselling to both members and non-members, but mostly members come forward for counselling. However, one participant said that people meet non-members at funerals of HIV-positive people, and this is where counselling starts. Counselling is important to spread awareness, and because people in a community should help one another. Counselling can be instrumental in non-members becoming members.

Rural Area: Of the participants asked, just over half said their churches provide counselling to everyone – because counselling gives people a chance to regain their health and learn about God. Only a few participants said that their churches provide counselling to members only, but expressed a desire to provide counselling to non-members as well.

The researcher finds it encouraging that counselling services are mostly provided to all people. In the context of counselling families, another dynamic would be if only one partner belongs to the church, and the family is in need of counselling. The training

programme would need to incorporate dynamics such as counselling families where some members belong to the church and others adhere to traditional African religion. Also there would be a need for clarifying that the process would not culminate in converting people when they receive a pastoral family counselling service. Training in multi-partiality and appreciation of the life world of people of other faith would be used to accomplish that.

Question Three

What are the most common problems the families are presenting to church counsellors?

The format for presenting this section is slightly different because of the number of common problems that were evident across all areas. These are discussed first, so as not to repeat them for each specific area.

Problems presented across areas were: unemployment, poverty (and other financial problems) and crime (sometimes caused by unemployment); domestic problems: family and marital problems; domestic violence, including the physical and sexual abuse of women and children; alcohol and drug abuse.

HIV/AIDS and related problems were mentioned across areas. Stigmatisation and discrimination was mentioned in the suburb, semi-urban/informal, and rural areas as was neglecting the sick and isolation and exclusion of the sick. These problems were alluded to if not mentioned by the participants from the semi-rural area: "the fear of telling others one is sick".

Lack of healthy food was mentioned by participants from the township and semi-urban/informal areas, and only by participants from Wentworth in the Suburb area. Lack of food, hunger and starvation was mentioned by participants from the semi-rural area (not mentioned in the rural area).

Unwanted/ unplanned and teenage pregnancies were topics mentioned by participants from the suburb, semi-urban/informal, semi-rural and rural areas. (i.e. not in the township area).

Rebellious youth and children were mentioned in the suburb, semi-rural, and rural areas.

Specific area based problems are now presented as follows:

Suburb: Unsafe sex, failure to disclose status to family members, bereavement, spiritual problems and health problems, lack of treatment.

Township: Violence. The fact that many children need counselling because they aren't happy in their families; and the fact that women are shy to ask their husbands to practise safe sex; sickness, finding out one's status, and lack of knowledge.

Semi-Urban/Informal: Lack of good shelters, lack of education, violence and the families that are affected by it, lack of support of families from fathers/husbands; illness, and married couples being afraid to tell their partners about their status. One participant said that in his/her church people deny the existence of HIV/AIDS and family problems, thus there is no counselling.

Semi-Rural: Community problems; finding out one's status, inability to accept one's status, and deaths in the church and community.

Rural Area: Social problems; incurable disease, sickness; conflict; not understanding one's situation, fear of sick people dying and fear for oneself; AIDS orphans in the church.

The extensive and detailed response of the participants to this question shows the magnitude of existing problems. Many of these are poverty and illness related, and often refer to power imbalances in the home, the latter being discussed by Kotze (2002) as well. Most of these problems are experienced within the family. Through prolonged engagement with the participants during the Siyahlanganisa training courses, the researcher realised that these problems recalled many stories of pain and injustice. Further, the problems of poverty and food insecurity would need for the training programme to link with existing programmes that target these concerns.

Question Four

Who offers counselling services in the church?

Suburb: This differs between churches. About half the participants said that in their churches it is just the minister/pastor/priest and sometimes assistants and lay-ministers

that do counselling, and that they give people marital, spiritual and pastoral counselling (and in one case HIV counselling). In one church only one of the ladies in leadership does the counselling, and she counsels mainly women. In the other half of the churches, there are many counselling services: Church leaders, youth ministries, old age ministries, men's ministries, women's ministries, children's ministries, cell group ministries, social aids ministries, VCT counsellors, social counsellors (these are including informal and formal counsellors), educators who deal with school related issues, health workers, who deal with HIV/AIDS and STDs and specialised ministries, where people deal with a variety of different issues.

Township: In most churches, the pastor provides counselling, usually spiritual counselling. In some churches, others also counsel; some churches have 11 to 12 counsellors involved in the church and community while some have fewer counsellors than this – one participant said that the reason for this is that people in the community are afraid of knowing their status; and in some churches members counsel other members. In one church a committee board deals with family problems and in another, it is the youth who provide the counselling. There were also cases where participants said that only the pastor provides counselling. Lastly, some participants said that they themselves would be the first counsellor in their churches.

Semi-Urban/Informal: This differs from church to church; in one participant's church the pastors and ten counsellors provide counselling, as well as there being counsellors in the community; in another, the church leaders provide counselling. In other churches only the Reverend provides counselling – marriage counselling and speaking to the youth about HIV/AIDS, telling them to abstain; or the pastor and his wife deal with family issues and people who are infected and/or affected by AIDS; or only the pastors wife provides counselling, and organisations in the community. One participant said that he/she is one of two counsellors in the church. In 3 churches, no one provides counselling, and the community turns to for help to nearby hospitals and clinics. One participant did not answer this question.

Semi-Rural: The question of who provides counselling in the church varies from church to church; in one participant's church, no one provides counselling, but (s)he wants to go back to his/her church and community and share knowledge and help those who are in need, as (s)he now is trained to do these things. In two other participant's churches they themselves provide the counselling; four participants indicated that their church leaders provide most of the counselling in their churches, and in some cases they are joined by more counsellors, who also provide counselling in schools, clinics, hospitals and in the community. One participant mentioned Diakonia to be providing counselling to people in their church. In another participant's church the youth leaders provide counselling to church members. Two participants did not answer this question.

Rural Area: In three of the ten participant's churches, the pastor provides the counselling. In one of these, doctors and the pastor's wife also provide counselling; in another, the participant and the pastor's wife. In other churches, counselling is provided by members (some of whom are also doctors), and members of the community. In one participant's church, counselling is only provided by the organisation: Channels of Hope (this under OADP supervision, in Okhahlamba). Another participant mentioned a support group: Sinothando. Counselling includes teaching the church about how young people should look after themselves, teaching the youth about HIV/AIDS, spiritual counselling, giving support and care to both bed-ridden patients and healthy infected people, marriage counselling, counselling about domestic violence, HIV/AIDS and poverty, and providing food parcels. In only one participant's church is no counselling provided, but counselling services are offered in the community.

The researcher realised that in all areas there are churches where only the pastor provides the counselling and other churches where counselling is also performed by lay counsellors. Counselling seems to be combined with supportive care and counselling education. VCT counsellors are also included and it is encouraging that participants have presented themselves as counsellors to their churches. The need for pastoral counselling is clear from these responses.

Question Five

Do churches provide counselling services to families affected by HIV/AIDS? What is the nature of these services? Do they perform home visits?

Suburb: Most participants said that their churches provide counselling services and perform home visits to families affected by HIV/AIDS, only one participant said that his/her church does not. One participant did, however, indicate that people must come forward so that counsellors can help them. Churches assist families with finances, food and transport to the HIV clinic. They pray for them and provide spiritual counselling. They also provide palliative care and bath people if necessary. They help retired people, sometimes by sending them to clinics. They teach arts and crafts, life skills, and teach about how HIV/AIDS spreads. One participant is involved in a ministry at the University of KwaZulu-Natal, The Bible Talks Student Ministry, which gives counselling to students, thus she said that much of her church's counselling is to students who are referred to wider support networks.

Township: More than half the participants said that in their churches counselling is provided for families affected by HIV/AIDS, as well as home visits. In these sessions, spiritual support is given – prayer, hope, sharing of the Word of God and showing people that Jesus loves them and cares for them. Also, physical support is given, especially for those who have no one to help them – providing people with clothes and food, checking their environment and filling/checking their pill counters. One participant said that in his/her church, counselling is provided but not home visits; while another participant said that people in his/her church don't want to talk about their secrets, so no family counselling is provided for families affected by HIV, but they do perform home visits to help people. One person said that no one in his/her church provides counselling to families affected by HIV, but members of the community do.

Semi-Urban/Informal: Most participants said that their churches do provide counselling services to families affected by HIV/AIDS, and perform home visits, that they preach and pray, and tell families that they must not judge those who have HIV/AIDS. They

give people hope and tell them to trust God and they empower them to feel more free to deal with HIV/AIDS – to be familiar with the disease and understand what it is and how to deal with it. One participant said that in his/her church they use the home cells to talk to families about HIV/AIDS. Two participants said that their churches do not provide counselling to families affected by HIV/AIDS. One of these said that families are visited, but are not counselled, only prayed for; and the other said previously that no counselling is offered in his/her church.

Semi-Rural: Two participants said that their churches do not provide any counselling to families affected by HIV/AIDS, but one of these thinks that counselling services and home visits to families affected by HIV/AIDS are definitely a must. Most participants, however, said that their churches do provide counselling to families affected by HIV/AIDS, as well as going for home visits. They said that their churches give information to people, assess and try to meet their needs, pray for them, teach them to abstain, and try to empower people, but that some people do not disclose their status.

Rural Area: Most participants said that their churches do provide counselling services to families affected by HIV/AIDS, and some do home visits. They said that in this way they empower people to know their status, help them to take their treatment correctly and sometimes involve doctors who are members of the church with this, that they teach people how to live healthy lives and how to prevent the spread of HIV/AIDS. During home visits they also provide prayer, bring food parcels and provide home based care. One participant mentioned that there is a support group in his/her church, and another said that with the help of the Hillcrest AIDS Centre and the Hillcrest Hospice his/her church is able to help the sick if they become worse. One participant said that his/her church is still busy formulating a plan to do home visits and provide counselling, and there were only two participants who said that no counselling services are provided at all for families affected by HIV/AIDS in their churches. One participant did not know whether his/her church provides counselling to families affected by HIV/AIDS.

The researcher realised that counselling services connected to churches make it possible to organise and refer to the required form of supportive care, e.g. transport,

material support and ART support. This is important, since the contextual background of several participant categories mention the high levels of impoverishment that prevail along with HIV/AIDS. Also mentioned is the spiritual support that the churches provide. Home visits and cell groups (small groups that meet at peoples' homes) are utilized to speak to families about HIV/AIDS, which will help to de-stigmatize the condition. These characteristics of Faith Based Organisations are also described by Samuel (2005).

Question Six

What are some of the problems that families affected with HIV/AIDS discuss with their counsellors?

In all five areas, problems mentioned included HIV/AIDS related issues as well as social and family issues; but HIV/AIDS stood out as the main issue (although this may be due to the nature of the course).

The problems of poverty (financial issues), unemployment, lack of jobs, and the lack of nutritious food and money were mentioned across all areas.

Across areas the issue of stigmatisation, rejection, discrimination, isolation of infected people and a non-caring attitude towards them by both family members and churches was a major problem. People fear this rejection and thus do not want to find out or disclose their status to their family and friends. They feel a lack of self-confidence, depression, loneliness and hopelessness, and don't want to or aren't allowed to take part in the community.

In the suburb, township, semi-urban/informal and semi-rural areas (not mentioned in rural area), participants mentioned that in counselling, healthy living practises for infected people (health, obtaining and taking treatment, opportunistic infections, precautions, modes of transmission, support groups) were discussed; as well as how to handle an infected person.

In the suburb, township, semi-urban/informal and rural areas (not mentioned in semi-rural area), the problem of children left behind by infected people who were going to die was discussed.

In the semi-urban/informal, semi-rural and rural areas, the issues of acceptance of one's status and situation; coping with other people's sickness and pain, especially being

powerless against it; and the lack of counsellors and other sources of information about HIV/AIDS and how to get help so as to be able to survive, were discussed.

In the rural and semi-rural areas, participants mentioned the fact that people are afraid to talk to their partners about safe sex, and of losing them because of this, and partners are unwilling to practise safe sex.

Suburb: Challenges people face, confidentiality, fear, fear of death and poverty after loss of breadwinners. They have material, financial, medical, social welfare and spiritual needs.

Township: The fact that people start to go to the traditional healers, and mix medicines. They are happy to see counsellors because they are told to go to doctors, and can't afford the cost.

Semi-Urban/Informal: There is fear of death; that infected people are not working; lack of education; and having no identity documents and birth certificates.

Semi-Rural: Substance abuse by people living with HIV/AIDS; deaths in the church and community, the loss of family members who are infected; difficulty in telling grieving families about one's positive status; pregnancy, drug abuse, lack of money to attend classes which are far from the community, and how to get pensioner's grants.

Rural Area: Fear of death. Although the church is attempting to empower people so that they become more open about HIV/AIDS, people still feel that they don't want to talk about their problems in the church;.domestic violence, disrespectful children, practical issues like disability grants, and not receiving any support from other family members.

The researcher realised from all this information that HIV/AIDS cannot only be approached as a bio-medical problem, but as a socially comprehensive health challenge, as mentioned by Cochrane (2008).   The participants put a strong emphasis on people living with HIV/AIDS still being stigmatized in their families and in their churches. In the rural and semi-rural area's condom use remains problematic within marriage relationships. These concerns need to be accommodated in the training programme.

Question Eight

In what ways have counselees benefited from the counselling services provided?

Participants from all five area types spoke about counselees gaining awareness, skills and knowledge about HIV/AIDS through counselling, and that this helped people to look after themselves and/or other infected people. The results were that people were beginning to live a healthier lifestyle, and also to adhere to their treatments correctly.

Participants also felt that counselees had been helped personally by counselling, they were able to assess their situations to take better decisions with clear minds, and also received information so as to be able to make better decisions.

Participants from the suburb, semi-urban/informal, rural and particularly semi-rural areas spoke specifically about counselees benefitting emotionally from counselling. They gain hope, strength, confidence and self-esteem. They are encouraged by the fact that someone is willing to talk to and listen to them, and can and wants to help them.

Participants from the suburb, township, and semi-rural areas spoke specifically about counselees (and families) being able to accept their status and thus move on.

Suburb: Counselling increases awareness and people become more willing to help each other. Counselees feel that they have been empowered by counselling; counsellors feel that patients' "dependence syndrome has been removed". People have been taught about conflict management, and conflicts have been resolved. Counselees have put into practice the counselling that they get from the counsellors.

Semi-Urban/Informal: Counselees also receive bereavement support. People feel stronger about their position, they feel that they can live their lives to the fullest, they feel free and happy and have no stress and they feel that they are the same as other people and so they also find it easier to talk about their status.

Semi-Rural: Counselees, through acceptance, suffer less stress and grief. They also find emotional healing through the Bible, and trusting God. They get information on how to join support groups and connect with other people in the community.

Rural Area: Counselees learn more about things they think they know everything about. They benefit from the support system that is available for them.

The researcher realised that the emotional support and acceptance of the HIV status stood out in the responses, as well as counselees being empowered with information about leading a healthier life style and information about ART, aspects that are seriously considered in the training programme. This empowerment process is also described by Nolen (2007).

Question Nine

Do churches refer families to other counselling providers? Why?

Of the 42 participants who answered this question, only 6 people said that their church does not refer people to other counselling providers. Most participants' churches, across areas, do refer people to other counselling providers.

Of the participants who said yes, from all areas, some gave as a reason the fact that there are not adequate skills within the church, and people need professional help. They also mentioned a lack of infrastructure and/or facilities within some churches; they cannot perform HIV-tests, CD4-counts or provide treatment.

Suburb: Referral serves as a supplementation and complementation of the services provided in the church. One participant' church refers people simply because there is a hospice in the area. Two people did not have access to confidential referral information. One participant did not answer at all.

Township: Some people who have been raped are referred to Bobbi Bear or the police. One participants' church does not refer people to outside counselling providers as the church counsellors help them to go to the clinics and to get treatments. Three participants did not answer this question.

Semi-Urban/Informal: Two participants' churches do not refer people to outside counsellors, but did not give reasons for this. One participant said that families in his/her church are not referred to other counselling providers because the counsellors feel that they are finished with counselling, and that there is no need for further help. One participant did not know whether his/her church refers people to other counselling providers but thought that they should do so if the situation is beyond their control.

Semi-Rural: Some counsellors refer counselees if their needs have not been met (e.g. the counselee has not changed their behaviour). Other counsellors refer people to social workers for grants and/or food parcels, and some refer people to other counsellors who do home visits. Only one participants' church does not refer people to outside counsellors, because his church does not have people who come to the church for counselling. One participant did not answer this question.

Rural Area: One participants' church does not refer people as they have many health professionals in the church; and another participant said that although his/her church does refer people, they are trying to show these people that the counselling at the church is the same as that outside the church.

The researcher realised the need for professional counsellors in the churches as discussed by Klein (2009), also in order to make proper referrals to professional specialised help outside of the churches.

Question Ten

Do church counsellors recognise a need for additional family counselling training and why?

Almost all participants indicated that church counsellors recognise a need for additional family counselling training. (Although of the township area participants almost half did not answer the question).

Participants, from all areas, gave as some of the reasons: A major lack of and need for counsellors in general, and a lack of skilled trained counsellors who know how to deal with a variety of problems.

A need for counsellors who know how to deal with and have training in dealing with family issues specifically, as these come up very often.

A lack of knowledge about HIV/AIDS both by counsellors and church and community members; training teaches counsellors so that they can "defeat the myths of HIV/AIDS", and teach people how to live healthy lives and communicate with others. Some people do not know that they have gaps in their knowledge.

Specific area based responses were:

Suburb: With training, counsellors would be able to better show their compassionate concern.

One participant said that he/she does not think there is a need for more family training for counsellors in his/her church, as the counsellors have already had training. One participant did not answer this question.

Township: Families deal with a lot of confusion when they are facing the HIV/AIDS situation, they need acceptance and encouragement. One participant said that his/her church would like to have more counsellors so that they can also help in neighbouring communities.

Those participants who said that the counsellors in their churches would not like more training in family counselling did not give reasons for this.

Semi-Urban/Informal: There is a high rate of people who need counselling, and also a large number of counsellors asking for additional training. Some previous participants at HIV/AIDS courses have already begun to provide training in the community and at schools. It was also noted by one participant that many counsellors are dealing with HIV/AIDS only; and that there is a need for counsellors who will deal with family violence, marriage problems, rape and drug abuse.

Very few participants said that there was not a perceived need for additional training in family counselling in their churches and they did not give a reason. One participant did not answer this question.

Semi-Rural: Counselling motivates people to get tested, and if they know their status early they will be able to get treatment early.

Rural Area: People need more counselling, they need time to get used to counselling, and they need professional help. Two people did not answer this question.

Unfortunately the participants who did not see a need for family counsellors in the church, did not give reasons for their opinion. Many of the participants who did see a need for the training related its value to a more general counselling outcome.

The researcher was aware that there might have been a fuller response to the question, if she would have explained the practice of family counselling to the participants. She

had expected them to understand the concept of family counselling and to answer the question in the context of the church. However, she had decided not to provide the initial information, because then the participants might have reproduced the information that she provided.

On the HIV/AIDS training courses, the distinction across the different geographical areas was often significant. Participants discussed their different life circumstances, available resources and distinct problem areas. The researcher noted that in answering the questions in this study, the differences were not that distinct. The strata are valuable, where they have provided a richer description and for reference purposes, but will need verification when counselling training and supervision is provided to these specific communities.

5.2.4 The following study was aimed at church based community counsellors regarding problems that families face in the communities related to HIV/AIDS.

Ten focus group interviews in different communities in Kwa-Zulu Natal, with church based counsellors

The focus group interviews were part of the monitoring & evaluation (M&E) process of Siyahlanganisa Centre. A team of workers and volunteers went on weekly visits to the communities where the course participants were based. The researcher together with a trained research consultant managed this part of the fieldwork.

Initially the team was trained in M&E skills by the researcher and a research consultant. The following topics were addressed and prepared: introduction to M&E (data collection, outcome evaluation, probability sampling, presentation of plan to clinic team, focus group discussion training (FGD) (interviewing, team debriefing, recording skills) FGD data analysis training (themes, report writing, recommendations) presentation of results to the clinic team and planned report back to focus group members.

Selection criteria for the FGD

A group of maximum 12 people was selected from a particular community in the greater Durban area through the training data base. The method of non-probability sampling was used and candidates were selected who attended training at different times, male, and female, different age groups and from different professional backgrounds. One person, who was known to be active and reliable, was asked to be the coordinator. This person would organize the venue (mostly a church or community hall, or the local library). Snowball sampling was used where the first people that were contacted would ask about other course participants, or on the day bring other interested people along. This created obstacles at times as these people would not have the same training experience or a church background in common. The researcher would never turn a person away and accommodate whoever would be present. The team would bring refreshments as an incentive for the participants.

The areas where the focus groups were held are set in the table below. The following communities were visited by the FGD team:

Table 5.6. Communities visited by the focus group discussion team, including number of participants, gender and language spoken.

Community	Venue	Number of participants	Male/female	Language used
1.Township	Church	6	Female	IsiZulu
2.Suburb	Church	8	Female	English
3.Semi-Rural	Care centre	9	Female	IsiZulu
4. Rural	Church	5	3/2	IsiZulu
5. Semi-Urban	Church	4	Female	English
6 Township	Church	5	Female	IsiZulu
7.Semi-Rural	Church	6	1/5	isiZulu
8.Suburb	Church	3	1/2	English
9.Township	Church	5	1/4	isiZulu
10.Semi-Urban	Church	5	2/3 (Total 8/48)	isiZulu

Duration of the FGD

The actual interviews were planned to last one hour. Often the researchers had to wait a long time before all participants arrived.

FGD guide

The focus group discussion guide contained general information about how to conduct a FGD. The format was as follows:

1. The researcher and co-researcher introduced themselves and stated the purpose of the FGD, "to find out about the response towards HIV/AIDS in your (church) community".
2. They discussed confidentiality and the use of the audio tape. Permission was obtained to tape the interviews and confidentiality was assured.
3. They discussed some of the ground rules, e.g. "your opinion is welcome, there is no right and wrong answer". Some of the FGDs were conducted in Isi-Zulu.
4. The participants were asked to introduce themselves.

Asking old course participants about their experiences, could give a certain bias, as they might want to tell us what they think we would like to hear. From the focus group discussions, that did not seem the case, maybe because on the training courses, participants were challenged to think and speak their mind, so this trend continued into the FGD.

The following questions were discussed:

1. When you think of family life in this community, what is the first thing that comes to mind? Tell us a bit about it…
2. What do you think the church should be doing concerning HIV and AIDS in the community?
3. What are the barriers that exist in this community that prevent the church from fulfilling its role in the context of HIV/AIDS? (Barriers in the church)

4. What are the possibilities that exist to remove these barriers?

The concepts discussed were categorised as: (1) family life, (2) the role of the church and its leaders, (3) barriers to change and (4) opportunities to overcome these barriers.

The first question was an opening question and put the focus on family life

The critical questions were meant to capture the intent of the study, to gain a better understanding of the problems people living with HIV/AIDS are facing and the help or facilities already in place to help them deal with these, as well as the perceived need for further help or facilities.

FGD outcome

The findings are summarised hereunder and represent mainly results that slightly deviate from other sample groups, this will help present a coherent picture without unnecessary repetition.

Question One:

When you think of family life in this community, what is the first thing that comes to mind? Tell us a bit about it…

Key findings:

- Young people are in need of role models, in rural areas families are dealing with overcrowding, unemployment, high levels of sexual activity, and almost daily burials.
- HIV-positive family members who disclose their status are treated badly and discriminated by their family.
- There is a need for information workshops on HIV/AIDS and parenting skills.
- Child neglect because of substance abuse in semi urban townships.
- Small children exposed to sexual images through media, but are not to ask questions.

- The wish of children to have nutritious food, and to experience no emotional problems
- Fear of crime: families are scared to do things since there is a lot of crime in the suburb.
- *"Family members need to be encouraged to speak openly about HIV/AIDS and go for HIV testing"*.

Themes from the afore-mentioned responses are:

- Lack of communication and parenting within the family.
- Need for open communication about HIV/AIDS within the family.

Discourses that are apparent from the responses are:

- Victimization within families with e.g. HIV/AIDS, domestic and child sexual abuse, non-disclosure maintains the family's good name.
- Information and knowledge empowers, helps healthy communication and creates behaviour change.
- Patriarchal system which looked after children and disciplined parental neglect. Parents learned skills within extended family.
- The 21st century's fast world, breakdown of family cohesion, lack of unity as family members are busy with different issues.

Question Two:

What do you think the church should be doing concerning HIV and AIDS in the community?

Key findings:

- The preaching in the churches needs to be more contextual and HIV education should happen before the Scripture reading, so that the Bible gets more

relevance. Pastors need to meet and network with other pastors, discuss relevant issues and mobilize the churches around HIV/AIDS, poverty alleviation and crime reduction.

- Churches need to get programmes for youth related to sexuality.

Themes from the afore-mentioned responses are:

- Being a contextual church
- The role of the pastor

Discourse that is apparent from the responses is:

- Theology of sin versus theology of encouragement

Question Three:

What are the barriers that exist in this community that prevent the church from fulfilling its role in the context of HIV/AIDS?

Key findings:

- *"Most of the time you cannot do anything without the pastors permission"*
- The issue of sex cannot be raised in the church, but it is within the Church that married men are having unprotected sex with young girls
- Sex education for young people is perceived as a disgrace, older people will say that you teach young people to sleep with men
- When people are sick and die, it's because they have been bewitched, people know about HIV but chose to ignore it is there
- *"Other churches are not well informed about HIV, they don't even think HIV exists, that is because their leaders don't want them to know about it. …if they hear someone talking about HIV they think it's a sin and they are embarrassed about HIV"*

Themes from the afore-mentioned responses are:

- Barriers are the attitudes **within** the church.

  (With this statement the initial question is challenged, as it suggests that the community puts barriers to the church, but the participants say that the churches put barriers to the community, because they are not in touch with reality).

- Denial by older people and church leaders about the realities of HIV/AIDS

Discourse that are apparent from the responses are:

- Discourse of judgment, stigma and denial within the church
- Discourse of sexuality in the Church.

Question Four:

What are the possibilities that exist to remove these barriers?

Key findings:

- To encourage Churches to support people living with HIV/AID, to give them hope through the Word of God.
- *"More people are open about their status because of us being trained. They were afraid to have an HIV test, but they seem to understand that if you are HIV positive, you can live longer if you take care of yourself and eat healthy."*
- Halls, schools and Churches need to put posters on the wall, so that education on HIV/AIDS becomes visible.
- *"People must be educated, pastors need to be trained"*

The theme from the afore-mentioned responses is: The need for a variety of means of education

The key discourse apparent from the responses is: A theology of hope and encouragement

Other key findings that came out of the discussions:

- Community counsellors and educators are perceived to interfere with people's integrity and therefore are avoided in the community

  "They don't want to be helped they think if u try to talk to them you will tell others about their status" …"they think we want to know about their personal affairs"… "Families do not want to disclose and talk to us, because we know them or they are neighbours."

- Counsellors should not use their own material resources for people but rather make strong referrals to social workers

Findings of the study:

For the development of the training programme the researcher realized that many of the problem areas as specified by the participants are related to parenting, substance abuse, issues of sexuality and masculinity, the need for supportive structures for the counsellors and a need for competent leadership. In most of the focus groups, the topic of sexuality was discussed related to sexually active youth and the cultural taboo on communication about safer sex practices. The studies that were earlier discussed also emphasized the vulnerability of children and youth and the case of oppressed women, having little control over their sexual practice. This was also discussed by Haddad (2002). It was Denis (2003:30) who suggested to re-construct the discourse of sex "as a force that needs to be domesticated, contained and moralized".

5.2.3 **The following study was aimed at church leaders. Focus group interviews were undertaken on the church leader's perceptions of the need and provision for family counselling services in their communities.**

The church leaders were part of fraternals, which are small groups of church leaders in a particular area who have regular meetings for fellowship, collaborative planning and community action.

The researcher conducted 3 focus group interviews, with 3 different fraternals in their respective areas.

The meetings were held in a rural, an urban area and in a suburban area.

The researcher made use of the purposive sampling method, "information-rich participants, with both depth and breadth of experience and who shared commonalities were identified" (Schurink 2001).

The focus group meetings were video taped, which documented non-verbal behaviour and communication.

For all the sessions, the researcher introduced herself and the study. She spoke about confidentiality, explained the purpose of the focus group discussion and then asked the following open ended questions:

1 What is your counselling practice like?
2 Where do you find yourself in your counselling practice?
3 Would you be interested in training in family counselling skills?

Group One.

The meeting took place with a group of 6 church leaders, who represented a number of Churches and fraternals in the rural area's to the South of Durban. Most of these

pastors are not fully supported by their churches and are working part-time and overseeing a number of congregations. They work mainly on a consultancy basis.

The meeting was held at a local community faith based organization. The discussion was translated in IsiZulu.

Discussion and key findings:

All pastors participated in the discussion. They were attentive and expressed concern for the realities in their communities.

They started commenting on HIV/AIDS, the researcher wondered if that was because of her being known to provide HIV/AIDS training, but they assured her that it was because of the overwhelming reality of the problems in their communities. The sense of being consumed by the realities of the pandemic is captured in the following quote:

- "*Those people that are sick are hiding the real ache of the sickness, so my plan is to approach the church to invite someone just to give them the basic information. "It's time people must want to test"*

The counselling practice was placed in a changing cultural context. The discourse of secrecy and denial of HIV/AIDS was approached in the following ways as described by participants:

- *"The person who is coming for counselling needs to open up and be honest, so that you can be able to give them the proper guidance that is needed"*
- *"As a leader I need to be willing to be educated (on HIV/AIDS), so that I can address people in an informative sense"*
- *"A person can only open up to one person, they will never talk with everybody at one time, they must have an "open confession"*

One pastor developed the strategy to build trusting relationships with people who he thought were living with HIV/AIDS and when they disclosed to him, he provided them with responsibilities in the church to "*keep them busy and give them a sense of self-worth".*

- *"from the church-sector, pastors should be involved in discussions about having conferences in our local set-ups, so that we are in a position to help"*

This quote is encouraging for the proceeding of the training programme as it shows the 'buy in' of the pastors.

The discourse of power relationships in the churches is addressed, where junior pastors are better skilled in relating to young people and can more freely talk about matters of sexuality, but still have to submit to their seniors.

- *"Very senior pastors find it very difficult to talk about sex".*

One pastor expressed a sense of freedom about visiting a 'bereaved home' and having joked with the descendents only to find that at the funeral they were all quite relaxed. He broke through the cultural norm that '*you can't just talk with everybody'* and discovered the function of 'humour' in counselling as described by Corey (2000).

Group Two.

The meeting took place with a group of 9 church leaders, who represented 9 denominations in an urban area in Central Durban. The meeting was held at a local church.

Discussion and key findings.

All pastors participated in the discussion, though initially expecting a talk, they were pleasantly surprised to be able to express their thoughts.

Family related work mostly is of a preventative nature as described in the following words of a participant:

- *"We are trying to equip multiple groups of people and prevent some of the problems that they might face"*

Counselling services are often provided at hindsight. Preventative work is also aimed at identifying problem situations in families as discussed by a respondent:

- *"Trying to counsel people about loss, grief, separation and divorce. Trying to do some damage control"*

Some of the churches are involved in community based projects e.g., work with street children and a home for abused women.

The role of the pastor is discussed. Pastors find that people are not always comfortable talking to them. They do not feel equipped to counsel in mental health cases. They are dealing with changed scenario's, for example during 'midlife crisis', the children are immigrating and '*the marriages are dead'.* They find that nowadays more of their time is taken up by counselling work.

The pastors showed interest in the family therapeutic counselling programme. They asked about the length and format of the courses, the psychological and pastoral models that would be used and requested input on intergenerational counselling as a frame of reference. One specified as follows:

"I feel that I'm trained for most things, but not necessarily for counselling"

The problems that families are facing are parental neglect, e.g. children are found to be left home alone whilst parents are at work, and unemployment. The churches lack voluntary support, as people are too busy in the weekends to involve themselves in community work.

Group Three.

The meeting took place with a group of 4 church leaders, who represented a number of Churches in a suburb to the west of Durban. Other participants were invited, but the coordinator changed the venue without consulting the people in good time.

Discussion and key findings

The group of pastors are ministering to a group of 300 people that live in the area and come to their churches.

Problems that families are faced with are mostly poverty related. The pastors are dealing with domestic abuse, lack of trust between partners, crime, neglect and teenage pregnancy. They claimed that 80% of their time was spent in domestic counselling.

Marriage counselling was approached from a traditional cultural perspective as exemplified in the following quote:

"Men want to apply authority over the spouse and it's difficult to blame a man in front of his wife, I take more of a mediating role" "they will voice out according to them what happened".

These pastors come across much hardship such as child headed households, and have to counsel HIV positive youth as described in the following words:.

"Pastor, what can I do? How can I approach my mom? And I encourage them that there is still hope and, you can still go on with your life and are precious to us, the church… it is challenging…it is painful".

The pastors show interest in the training programme as expressed in:

"If you can come up with a guideline on this community, we would be very interested".

"The church has a voice, but doesn't have resources, which makes the church powerless"

Findings of the study

For the development of the training programme the researcher realized the benefit of undertaking focus discussions and being able to look into the life worlds of a diverse group of church leaders. The church leaders all seemed to perceive their task as a 'calling', and stepped out into new fields of work, obliged to care and counsel. The researcher found it encouraging that all groups embraced the prospect of training and connected its value directly to their practice. They asked for an informative and reflective training mode. The pastors expressed their concern about the realities of HIV/AIDS infection in their communities and required training as well as guidance in the management of HIV/AIDS prevention, counselling and support in their communities. The proposed leadership programme might fulfil that expressed need and position pastors in a role where they can fulfil their passion as also discussed by Ganzevoort (2004).

5.3.6 Questionnaire interviews with 36 church leaders (at the time being trained by Siyahlanganisa centre) related to the outcome of their training

The following is a study on a sample of church leaders from various churches sampled from different areas in KwaZulu-Natal. All these leaders were participants on a course given by the Siyahlanganisa Centre: The HIV/AIDS Advanced Community Counselling Course for Church Leaders and Lay Counsellors. Thus, the sampling method was non-probability convenience sampling, the sample taken from the population of church leaders who attended this course. This causes some bias in the findings in that they reflect only those feelings of church leaders who attended the course, and thus are already active with regards to HIV/AIDS. However, the results are helpful in planning the family therapeutic counselling programme.

Question: Are you leaving [the course] with fresh ideas of how to take the next steps in addressing HIV/AIDS in your ministry?
Thirty six church leaders (including 32 males and 4 females) answered this question. More than half (20) of them mentioned teaching, educating, handing out pamphlets,

training, conducting workshops, calling meetings, inviting guest speakers, preaching, speaking and explaining to others about HIV/AIDS as part of their answer. These "others" sometimes included all church members, but also mentioned were the youth, preachers in a certain church (who were to be taught about how to address the issue of HIV/AIDS from the pulpit) and ministers at a college. One participant planned to start an "intensive educational and awareness program" in his/her church. Another said that churches should use every opportunity to speak about HIV/AIDS. Nothing was seen to be as important as telling others about HIV/AIDS; of the other "fresh ideas" mentioned, each was put forward by less than 10 people.

The next most mentioned "fresh idea" by church leaders (13), was helping infected and affected people. They mentioned helping church members and community members to make plans on how to deal with their situations, creating care/support teams and support groups in their churches, protecting the infected, and looking for and helping the sick. One participant said that he would support his client until death. Material help mentioned by 4 participants included fundraising to fight the HIV/AIDS pandemic, gardens, soup kitchens for the poor, a tent crusade to feed people, and, more generally, finding and attending to people's needs. Only two participants explicitly mentioned spiritual help and giving people hope.

Dealing with psychosocial problems (explicitly mentioned were domestic violence, child abuse, and giving crisis support and bereavement support) was mentioned by four participants. It was believed that people should be more empathetic towards victims of psycho-social problems, and not judge them. Participants thought of conducting a workshop or "involving men in some programmes" in order to change people's mind sets about psychosocial problems.

Three participants mentioned encouraging people to disclose their status and trying to break the silence around HIV/AIDS; a further two mentioned that they planned to work on changing people's mindsets about HIV/AIDS, and the way they treat others, teaching

them not to discriminate against and judge other people. One participant said that he had gained "new eyes and vision".

The fact that church and community members look up to and trust church leaders was mentioned by three participants. They felt that after completing the course, they were more equipped to deal with issues surrounding HIV and the community; and could identify with what HIV-positive people have to deal with.

Other topics mentioned by participants included the fact that church leaders planned to organise the HIV/AIDS work in their churches, by forming committees, or forming a ladder of responsibility; plans to enforce the program they had learnt on the course in churches, to draft policies on HIV/AIDS for the churches, to write community profiles in order to learn more about the resources and needs in their communities, to imply the word of God, to start counselling (although this is dependant on people coming forward for counselling).

Church leaders also mentioned that they personally had learned much from the course. They had gained information, and clarification about HIV/AIDS. They had also learned the steps involved in community development and about conflict management between church and community members.

The variety of responses to this question demonstrate the differing needs and contexts of communities, making it necessary for an effective training programme to always be culture and context specific as discussed by Kasiram (2009). Also apparent from these responses, is the common thread of similar needs and problems such as poverty alleviation, stigma and discrimination, spirituality discussed in step 3 of phase 1.

Question: Are there challenges for the future in which you would like more support?

Thirty three church leaders (including 29 males and 4 females) answered this question; there did not seem to be a prevailing answer such as with the previous question.

Ten church leaders mentioned a lack of resources, facilities and/or trained personnel as a "common challenge" for which they would like support. Church leaders saw a lack of facilities as "a challenge towards future relation support and proceedings"; they also said that there is a lack of resources "like working materials". They saw a need for "trained counsellors with skills and techniques" who could help people spiritually and physically. One participant mentioned providing training to the church care team, while others brought up providing training to church leaders. Fundraising was a challenge put forward by a further five church leaders. One of them mentioned specifically the problem of a lack of financial support from the church. This finding relates to the earlier mentioned finding that without adequate infrastructural support, success of family therapeutic counselling cannot be assured, hence the need for networking and collaboration across all stake holders. This was also mentioned by UNAIDS (2005).

In contrast to this need, one church leader said that he needed help in convincing the "local clinic to open the door for other people who want to help society", and another said that his "only concern is the diversity of the community when it comes to accepting aid."

Church leaders saw the need people have to learn skills with which to help other people; five leaders mentioned this explicitly. People want to learn more about HIV/AIDS, as well as how the pandemic affects the church. They want to learn how to look after infected people, and how to help sick people to get well, as well as other ways in which to assist people. Also mentioned was that church leaders want support in challenging and promoting church members to help those who cannot help themselves, for example to help infected people to take their medication.

Four church leaders saw support from the authorities and outside organisations as important. They wished to seek the support of different government departments, state governments, community leaders, organisations, individual churches and individual people. One participant mentioned needing help in contacting these authorities. This

watch-dog function is also discussed by Kasiram (2009) as supporting all HIV/AIDS endeavours.

Help to form a support group for infected and affected people was also put forward by four church leaders. One participant said that he/she would "like to establish a network of people living with AIDS to support people and protect them against abusers"; another said that it is his/her "challenge ... to encourage the church to form a support group to help the needy and sick people and the victims of psycho-social problems."

Three participants said that they saw a need for more refresher courses, and ongoing refresher courses. One church leader said that those in his/her church wanted to be invited to refresher courses. A further three participants mentioned applying what they had learnt on the course as a challenge for which they would like support. They wished to apply their knowledge in their personal lives, their churches and their communities.

Becoming counsellors and learning about different methods of counselling was a topic brought forward also by three church leaders. One leader also mentioned that he/she would like to know "what new information has come to counselling."

The following topics were mentioned by church leaders as challenges for the future in which they would want support: Help to review what has already been done; to write a proposal; to find actions to fight the HIV/AIDS pandemic; to create a programme for each day; help from all those involved in HIV/AIDS education to educate people and help to train people in teaching and facilitation skills; Help to establish drop-in centres at churches; to create a counselling centre where the participant "will be called a pastor and counsellor" and to implement modules in the church and Bible College; Help to support the community; to deal with the challenges in the community; to perform hospital visitation; to do practical counselling; to gain more information about community development; to see the church "involved in HIV/AIDS programmes so that [the] community will be well informed."; and to "attract men in the fight against HIV/AIDS"

The findings of this questionnaire showed the willingness of church leaders to be trained and become active as counsellors and pastors in their communities. The strength that comes through in this study is the organisational skills of the pastors. The training programme in family therapeutic counselling would channel and harness these skills to ensure that comprehensive services with the help of appropriate networking prevails, and that pastors may be enabled to reflect on their own lives whilst gaining skills in pastoral therapeutic counselling practice with families.

5.4 Step Three: Design of the Intervention Research Model as adapted from De Vos (2001:385)

5.4.1 Discussion of research findings with HIV/AIDS support group

This discussion was informal and aimed at securing a review of the programme by firstly engaging with relevant stakeholders using reflecting, clarifying and discussion of the key components of the programme. The group members were satisfied with the content presented to them, but added that there should always be a support group for family members, affirmed the need for spiritual support and that church leaders be informed and non judgmental in their approach.

5.4.2 Discussion of research findings with three church leaders and theological educators

The researcher also met with the following church leaders and theologians to obtain a peer review of the proposed programme: (1) the principal of a local Bible College (2) a lecturer at an accredited Saturday Bible College for laity and (3) a senior high profile minister in a main line church, with experience in leadership development. These meetings had the character of a peer review or debriefing of the research exercise and final training product (part of validating the product). The purpose of the discussions was also to approach the concerns about families living with HIV and the approach of the Churches from the vantage point of these leaders. The leaders asked critical questions

related to the target group, course content and possible integration in the programmes of the Bible Colleges. They asked about the accreditation of the courses and suggested to present the training more as a refresher programme for pastors that already received training in pastoral counselling.

The developed data, from the initial field research and literature research were thus verified with people living with HIV/AIDS, church leaders and lay-counsellors, and theological educators.
The data were used to specify and define what needs to be changed:

- Many families are living with HIV/AIDS.
- Families living with HIV/AIDS cannot deal with their problems, e.g. extended grief.
- There is a lack of trained pastoral family counsellors.

These points were used to justify the need for further training courses for pastoral family counsellors. Furthermore, the data was used to assess what should be included in these training courses, and how they should be designed.

5.3.3 The observational system was designed to be able to assess the course participants' knowledge base, skills, quality of counseling, personal development and report writing.

The researcher followed Operational step One from Phase Three from the Intervention Research Model in realizing this goal of assessment.
Preamble
Initially, the researcher planned to conduct two pilot studies. The first pilot study was held at a Bible College and the second pilot study was held at a local church with church leaders and lay counsellors. These two pilot studies had a different target group, but followed a similar course outline. The researcher realised then that the course would have a better structure if one part of the course would focus on bereavement and trauma and the other part on mental health problems. With this in mind, she conducted a third

pilot study for faith based community leaders in family therapeutic counselling in bereavement and trauma.

Knowledge Base.

Pilot study one was conducted at a Bible College:

The researcher obtained the study guides from the Bible College where the first pilot study took place and placed the contextual and narrative family counselling course in the second year of study, after the students had completed their modules on basic counselling, advanced counselling, and marriage & the family.

The researcher designed a similar format as the existing modules An initial practice based manual and Reader was developed that provides information about psychosocial problems, skills development, and counselling approaches and exercises.

The students' knowledge base was assessed at several intervals through the training course.

The students wrote multiple choice tests and answered open ended questions. They prepared for presentations on mental health problems, learned to design case studies and wrote an assignment.

These indicated that the participants would be able to understand and apply the contextual and narrative language to several mental health problems and were capable to understand and apply the concepts discussed in the genograms.

Pilot study two was conducted at a local Church:

The researcher and the church coordinator advertised the training course at different churches in the suburb for advanced and experienced counsellors. The outcome was a group with a diverse knowledge base, and at times the researcher needed to put more basic information and understanding in place.

The knowledgebase during the training course was assessed at the end of the course by means of a multiple choice test and a test with open ended questions.

The participants would be able to understand and apply the contextual and narrative language to several mental health problems and capable to understand and apply the concepts discussed in the genograms.

Pilot study three was conducted at a hospice:
The participants represented community based organizations and most participants already worked in the area of counselling. The participants were lacking basic knowledge on mental health issues.

The knowledge base during the training course was assessed at the end of each day by means of verbal course evaluation. The participants would develop a knowledge base in contextual and narrative language related to grief and trauma.

Skills
These were mainly assessed through role plays.

Pilot study one
Theory on contextual and narrative family therapy was provided in lectures and practical application took place in personal genogram work.

Family counselling skills were taught through lectures, case studies developed and practiced through role plays.

Pilot study two
Theory on contextual and narrative family therapy was provided in lectures and practical application took place in personal genogram work.
Family counselling skills were taught through lectures, case studies developed and practiced through role plays

Pilot study three

The skills development followed the same procedure, with a difference in the role playing. Because there were 25 participants, the researcher decided to have a trio of counsellor, counselee and observer. In that way all participants had an opportunity to partake in the role plays and the observer discussed the outcome with the group

Quality of counselling

Pilot study one

Quality of counselling skills was improved through the increased knowledge base, extensive discussions, which created deeper understanding of people and their problems. The personal genogram work brought it home and specifically the case design and role playing created the opportunity as a team to become better skilled as a helper and counsellor. The role playing was not aimed at creating a 'drama' but rather to develop an understanding with the students of what attitudes and skills are helpful in a counselling and therapeutic relationship.

Pilot study two

The same outcome as under pilot study one, except that the diversity in the groups made that highly skilled counsellors could not develop from their level of competence as others still needed to catch up with basic counselling skills

Pilot study three

The quality of counselling was enhanced as the knowledge base increased and understanding developed. Grief therapy was discussed, but not adapted as a counselling skill as participants were aware that they would need to refer to professional counsellors and gained the skill of assessment for referral.

To ascertain quality of counselling became hands on work and painstakingly applying and trying again as a group to understand better and develop more insight and empathy.

Personal development

Personal development assessment was a combination of self assessment, group debriefing and the researcher's evaluation of each participant.

Pilot study one

The students were expected to do individual work, preparatory work, take account of their own family history, prepare in teams, partake in debates and discussions, prepare for devotions and practice skills. Personal problems or issues might service and could, with the participant's permission be used as 'material' that would encourage personal growth and development

Pilot study two

The same outcome as under pilot study one, except that the course was spread out over 10 weeks and therefore in the three hour meetings, the participants seemed less committed in applying themselves to all the different tasks.

Pilot study three

The participants developed through group discussions and their personal family work. These participants were mostly affected by HIV/AIDS in their own homes and communities and the training course in bereavement counselling was 'heavy' and at the same time transforming.

Report writing

The skill of report writing was seen as important to assess, because this is an area for church leaders that has been under developed. Church leaders often do not write reports on their counselling sessions. They also may lack confidence in writing journal articles and therefore their writing skills in the case studies are assessed. This was discussed by Wheeler (1996).

Pilot study one

Students were expected to write a case study, either based on their own genogram or on one of the presented mental health problems. The students learned to make use of the format of a single case design.

Pilot study two

The participants were lectured on the topic of report writing and given an exercise to write. The final examination contained a case study.

Pilot three.

The participants were presented with a model of a case study, before they designed their cases for the role plays.

5.3.4 Procedural elements of the intervention were specified e.g. the need for training, working with gate keepers, planning, contextualizing of course material, marketing, implementation, evaluation and supervision.

Training need

This is a key area, because the researcher wants to establish the need for a training programme in family therapeutic counselling.

Pilot study one

The Bible College realized the need for more advanced training in specific family counselling skills. The training course was presented to the students as an elective and therefore all 10 students enrolled on a voluntary basis and needed to pay an additional fee for the training course. The training need was discovered, where the students had limited supervised practice during their counselling modules and were not familiar with the counselling skills as practiced with families. There was also a need recognized for practice based training in issues of mental health. The material that the facilitator presented is directly linked to existing practice models, e.g. SANCA in Durban.

Pilot study two

The senior pastors realized the need to improve their counselling skills and inquired about the possibility of a training course specifically in couple counselling and issues of mental health.

Pilot study three

The hospice realized the need for a course in family counselling and grief counselling

The researcher realised that assessing the need for training is an outcome based activity, which made her decide to keep the course design flexible, so that different groups or churches can request their specific training needs. This was also discussed by Neville (1999).

Working with gate keepers

Working with gate keepers is important in order to establish the right connections and resources and to have the correct target criteria met.

Pilot study one

The direct communication with the principal of the College was helpful. The facilitator stayed with his family, so there was more opportunity to interact and iron out any practical problems as arising during the course, e.g. absent students

Pilot study two

The direct communication with the pastor of compassionate ministries, who coordinated the course, was helpful. The pastor created access to all the resources.

Pilot study three

The director of the hospice in Swaziland is also a senator and therefore one of the members of the royal family opened the workshop. All the formality was important for the publicity of the hospice, but took valuable training time away

In this study, the gate keepers were all motivated for the training to take place.

Planning

The planning phase was important as the researcher linked the findings from the literature research and field studies, with the design of the course materials, the observational system, and the characteristics of the course participants.

Pilot study one

The researcher planned the course objectives, course outline, course content, the pre- and post assessment, and the examination papers. The researcher also discussed the practical aspects of the course, e.g. duration, break-times, refreshments, lunches, and designed the budget for the course, e.g. cost of materials, transport.

Pilot study two

The researcher adjusted the course outline, the course content, the pre-and post assessment and the examination papers. The researcher also discussed the practical aspects of the course, duration, break time, refreshments, and designed the budget for the course, e.g. cost of materials, transport.

Pilot study three

The researcher re-designed the course outline, the course content, pre and post assessment. The practical aspects of the course were all organized by the hospice. The researcher designed the budget for the course, e.g. cost of materials, transport and accommodation.

Contextualizing of course material

Contextualizing of the course materials is important, as the participants need to recognise and relate to the problem situations that are going to be discussed.

Pilot study one

The researcher identified the student profile, so as to design course material that will fit their context and at the same time will challenge their contextual comfort zone.

The researcher also familiarized herself with the context of the Bible College, their aims and objectives, their theological orientation and external accountability. The researcher also took cognition of the areas of work that the students are going to be involved with, to incorporate some of these challenges in the course materials.

Pilot study two

The researcher amended the course material to fit a shorter course. Pilot study two was provided with a manual that contained the course content and with a small Reader.

Pilot study three

The participants were provided with a manual with the course content. The researcher researched the reality of HIV/AIDS, the cultural influence and the service provision in Swaziland and integrated the reality of cultural beliefs in the course material

The context of the 3 different groups varied, even within the groups. Participants have different cultural backgrounds and therefore the material needed to be relevant to them and to the families to whom they were going to provide counselling.

Marketing

In order to create a market, the training programme needed to be marketable and conform to standards as for example set by the National Strategic Plan for HIV prevention, treatment, care and support (Kehler 2007). This plan does not specifically speak about family counselling, but mentions family attitudes and structures as a barrier to ART support and mentions home based care, which is a primary referral source for family counsellors.

Pilot study one

At this stage of the research process, the course design needs to be marketable to prospective students. The researcher designed a brochure that was presented to the students, which advertised the training course and provided realistic information about the requirements set to the potential students.

Pilot study two

At this stage of the research process the course was marketed to the local churches and the researcher visited the fraternal, which is a group of church leaders from a specific area

Pilot study three

The course was marketed through the hospice with several service providers. The course was also advertised in a national newspaper.

Implementation

This applied to all three pilot studies.

More direct planning was done about the exact format of the training course. The researcher refined the materials, informed by regular communication between all the stake holders.

Evaluation and supervision

Evaluation of the training programme and evaluation of the participants family therapeutic counselling skills is important in order to develop and maintain a quality standard of counselling. The researcher, taking the position of not being the expert, engaged in a "recursive interaction between shared values, the supervisors' observations and the students' performances", here with fellow participants taking the role of clients (Flemons et al 1996).

The genogram is used as a discourse of the participant's family stories (Mcvean et al 2001). By means of symbols the participants explain their family history and make use of

contextual and narrative language to explain dynamics in their family. The participants are also introduced to a spiritual genogram, as to gain a better understanding of the role that spirituality plays in their (multigenerational) family of origin (Wiggins Frame 2000). Other creative ways of programme feedback are sculpting and genogram presentations (Deacon & Piercy 2000).

Pilot study one

The researcher designed a course expectation and evaluation form, in order to ascertain any changes that took place related to understanding and opinion. Several assessment tools were designed to continuously come alongside the students in order to observe and help their development, e.g. the case design. Ongoing supervision of the students counselling skills, and using 'live families' was a practical constraint, as the students were moving in all different directions after their graduation. During the course, some students started practical work with families and discussed their findings with the researcher.

Assessment criteria: 3 tests within the duration of the course, seminar presentations, reading reports, role plays, a final test and an assignment.

Pilot study two

The researcher used the same course expectation and evaluation form. As mentioned before, several assessment tools were designed to continuously come alongside the participants in order to observe and help their development. The researcher provides supervision to one of the counsellors, who is a social worker.

Assessment criteria: role plays, a final multiple choice test and an assignment.

Pilot study three

The researcher used the post questionnaire. Unfortunately, because of the official opening, there was no opportunity to do the pre questionnaire. In this group the genogram was an important tool as it helped the participants to process some of the material they were dealing with in the duration of the course.

Assessment criteria: case design and role plays

5.5. <u>Step Four: Early Development and Pilot Testing of the Intervention Research Model as adapted from De Vos (2001:385)</u>

This part of the training development is concerned with the mode of delivery, selection criteria, selection and specification of intervention procedures

5.5.1 Development of the prototype programme

Mode of delivery
The mode of delivery is important, because the course needs to be presentable, informative and attractive to the students. After the course the student would need to use the manual as a source of referral.

Pilot study one
The manual contains of a course outline and a reader.

1. Course title: Contextual & Narrative Family Therapy Skills Training
2. Course code: 160 notional hours (16 credits)
3. Course Description: Introduction to contextual, narrative and spiritual family therapy and the development of counselling skills in the areas of abuse, chronic illness, depression, parenting and eating disorders, in the context of the HIV/AIDS pandemic in South Africa. These mental health problems were selected by the

students, taken into account that other relevant topics were catered for in other modules of their training programme

4. Course format: The course was held for 10 days. The class combined lectures, readings, case design, demonstrations and discussion. The daily programme was divided in family therapy theory and practice skills (21/2 hours), chapel time (1/2 hour), introduction to mental health problems 11/2 hours), case design and role play (21/2 hours)

5. Learning outcomes.

As mentioned in Chapter four, in outcome based learning the learning outcomes are learner centred, focussed on knowledge, skills, attitudes and values and the outcomes are future orientated (van der Horst and McDonald 1997).

Know: gain insight in a contextual, narrative and spiritual approach to working with families in South Africa.

Be: a knowledgeable, skilled, kind and prayerful counsellor.

Do: apply counselling skills to help families with problems.

6. Learning programme for Day One of this course. The learner will be able to:

Table 5.7. Learning Programme, Day One of Contextual & Narrative Family Therapy Skills Training .

Learning session outcome	Methods
Practice spiritual discipline	Meditation
Know the content and purpose of the genogram	Lecture
Acquire skills in making genograms	Practical application
Gain insight in personal family history	Evaluation
Gain understanding of the problem of abuse	Lecture
Discuss the contextual and narrative approach to families dealing with abuse	Group discussion
Design a case study; gain skills in team work	Case design
Engage in family counselling	Role play
Assess the counselling session	Evaluation

Pilot study two

The manual contains of 65 pages with copies of the slides of the accompanying power point programme. The researcher preferred this mode of delivery, as the participants only need to make additional notes to the existing text.

1. Course title: Advanced Family Counselling
2. Course Description: introduction to contextual, narrative and spiritual family counselling and the development of counselling skills in the areas of teenage pregnancy, chronic illness, domestic violence, bereavement, suicide, mood disorders, substance abuse, post traumatic stress disorder, poverty.
   These mental health problems were selected by the participants
3. Course format: The course will be held for 40 hours. The class combined lectures, case design, demonstrations and discussion. The daily programme was divided in family therapy theory and practice skills (11/2 hours), introduction to mental health problems and case discussion (11/2 hours).
4. Learning outcomes.
   Know: gain insight in a contextual, narrative and spiritual approach to working with families in South Africa.
   Be: a knowledgeable, skilled, kind and prayerful counsellor.
   Do: apply counselling skills to help families with problems.
5. Learning programme for Day Two of this course. The learner will be able to:

Table 5.8. Learning Programme, Day Two of Advanced Family Counselling Course.

Learning session outcome	Methods
Practice spiritual discipline	Meditation
Engage in the icebreaker; In your immediate or extended families, who are the Clowns? And who are the Hero's?	Ice breaker
Know the Genogram: psychological information that influences 'the life' of the family	Lecture
Acquire skills to apply to your own genogram	Practical application

Gain understanding in counselling in Chronic Illness • Brainstorming • Perceptions	Lecture
Discuss the Counselling in Chronic illness Case study	Group discussion

For the detailed 13 day course outline see appendix (2)

Pilot study three

The manual contains 28 pages.

1. Course title: Bereavement Family Counselling Course
2. Course duration: 40 hours
3. Course Description: introduction to contextual, narrative and spiritual family counselling and the development of counselling skills in the areas of trauma and bereavement

   These topics have been requested by the organizers of the course
4. Course format: The course will be held for 40 hours. The class combined lectures, case design, demonstrations and discussion. The daily programme was divided in family therapy theory and practice skills (4 hours), introduction to mental health problems and case discussion (4 hours).
5. Learning outcomes.

   Know: gain insight in a contextual, narrative and spiritual approach to working with families in South Africa.

   Be: a knowledgeable, skilled, kind and prayerful counsellor.

   Do: apply counselling skills to help families with problems.
6. Learning programme for Day One of this course. The learner will be able to:

Table 5.9. Learning Programme, Day Three of Bereavement Family Counselling Course.

Learning session outcome	Methods
Practice spiritual discipline	Meditation
Engage in the icebreaker: Thick and thin: make a sculpt	Ice breaker
Know the Genogram: the family as a relational system	Lecture
Acquire skills to apply to personal genogram	Personal application
Gain understanding in complicated grief work	Lecture
Discuss the complicated grief work case study	Case discussion
Design a case for complicated grief work	Case design
Engage in family grief counselling	Role play
Assess the counselling session	Evaluation

In the view of developing training courses, examples of problems facing families living with HIV/AIDS were provided as case studies and translated in operational terms (contextual and narrative family therapy).

Realizing the potential of the participants in all three pilot groups, the researcher decided not to use these existing cases, but rather train participants in skills to design their own case studies, which provided more ownership and the provision of contextually designed cases. In order to design the cases, the participants had to utilize the course materials and educated each other as a group, developing better theoretical understanding, awareness of ethical issues, insight and sensitivity. The students were enabled in their groups to "look at the issues that blocked their understanding or communication with others" (Wheeler 1996:83). Doing the genogram work, made the students more aware of the context of such issues, e.g. relating to clients expressing controlling behaviour.
The groups verified their understanding with the researcher.

5.5.2. The course is piloted in three different situations: at a Bible College, at a local Church and at a Hospice

Course Objectives:

The Course objectives apply to all the three pilot studies:

1. To provide students with a practical understanding of contextual and narrative family therapy skills.
2. To equip students with theoretical concepts and methods to practice family counselling.
3. To introduce students to psycho social counselling
4. To mainstream HIV/AIDS and poverty in pastoral family practice.
5. To equip students for a multicultural and non-discriminatory context.
6. To integrate spirituality in family counselling.

5.5.2.1 The First Pilot Course:

The researcher conducted the ten-day training programme with a group of ten students from the Bible College. The students represented different parts of the country and different cultural backgrounds. There were two Afrikaner-, two Zulu- , one Suthu- and two coloured female students from the Cape and three students from rural Transkei.

The following information comes from the students' course expectation and course evaluation forms and from the researcher's notes.

This section has been extracted from Den Hollander in Kasiram et al 2006.

Motivation to attend the training course

Most students were motivated to do this course because of the need of people in- and outside of the church for family counselling. They realized that most pastors in congregations are not equipped or do not have the relevant qualifications and knowledge to help people attend to their broken families and to strengthen those that seem to be healthy. They realized that their role is not only about preaching. Students recognized the current disintegration and break down of families and affirmed the role of families as building blocks of society and their sacred position within the body of Christ.

Students wanted to gain knowledge of these problems and use the right methods and techniques in order to help families and individuals with problems occurring in their lives. Some students expressed concern that it may not always seem fit to work with the whole family, e.g. when a person does not want to speak in front of the family about confidential issues, when a person may not express him- or herself enough because of the family presence or when family relationships are very destructive.

After this course the students want to get involved in family- and community development, work with young people, pre-marital counselling and long-term family counselling. They want to be pro-active and ask families how they live back home and attend specifically to young married couples where partners threaten each other with divorce.

The genogram

- The students were asked to draw their own family genogram and every day applied new information to it, e.g. family systems theory, basic concepts of contextual family therapy, externalizing and re-authoring of family conversations. For example when adding the ethical dimension the following questions were asked:

- Describe loyalties in the family relationship. What are the family's expectations, obligations, the balance of entitlement and indebtedness? Is there trust between family members?

- Answer this for horizontal- and vertical relationships

- Are there split loyalties/invisible loyalties?

- Describe the legacy component in your family. What are the roles and values that are acquired by your family of origin? Is there a revolving slate?

One of the students mentioned that if the genogram work had not happened as part of a process, she would not have been able to do work on the above mentioned questions. Taking her through the process of every day information and application enabled her to do this work. Another student said: "I know myself according to my genogram and my background and the story about me."

All the students decided to present their mostly three- generational genograms to the group. They pointed out the quality of the relationships, the nodal points, the patterns, issues of entitlement, loyalties and legacies, internalized messages, dominant practices, problem saturated stories, unique outcomes and alternative life stories. Sometimes the stories generated grief or brought about pain and sometimes the stories were humorous or ironic and made the group laugh. Specially when messages were externalized or insight was gained there was a sense of ownership, freedom and relief. As described by Morgan (2000) and Boszormenyi-Nagy (1981).

The last evening the students started spontaneously telling child hood stories and coming from such various backgrounds did not hinder them but was enriching. The themes were shared though differently experienced. For example 'man hood' was discussed and what happened when the male role model in the house was missing.

As much as these students lived together and studied together they had not shared their family life stories to the extent that they were enabled to do that by use of their genogram. This created insight into their own family background helped them to identify areas of concern, created more transparency, helped them practice values of trustworthiness and truthfulness and produced a great amount of bonding in the group. Students reserved themselves the right not to disclose everything in front of the others and called that "holy ground".

Mental health presentations
What occurred related to the work on mental health issues were spontaneous discussions initiated by the students about topics that would arise in their minds. This to the author was an example of where the community of students would raise theory laden questions and discern communal wisdom using their own cultural resources. For example they discussed gender issues in counselling, widow inheritance, name giving in African culture, issues of touch in counselling and manipulation in relationships.

When presenting the seminar presentations on mental health problems, the students would find additional information or illustrations, share their own experiences, which often meant their disclosure of dealing with these problems in their own lives and used the concepts from family therapy in their presentations as they had come to experience the usefulness of those, e.g. one student drew a monster on the board representing anorexia and did a little skit with another student having her internalize negative messages about herself.

The case studies were designed around the same mental health problems. The students took their time to design them by taking cultural realities, family dynamics and specific problem areas created by the given problems into account. The first week was solely spent on case design. In the second week the same case scenarios were role played. At first it was rich drama, but then the students took to the counselling reality and were happy to be stopped and have dynamic or technique explained and repeat it several times until every one was satisfied.

The contextual technique of multiple partiality was practiced and helped students overcome some of the initial barriers in family counselling.

The course impacted on the students in the following ways:
- They gained new self perspective, the course made them think about themselves.
- They better understood the impact of family and learned to work with people contextually and understand their point of view.
- They gained information on e.g. domestic abuse and know better how to help victims of abuse and also gained information on chronic illness and how best to counsel families dealing with a patient in the home situation.
- They were better equipped in helping families to deal with problems and felt more competent to counsel.

5.5.2.2 The Second Pilot Course

The researcher conducted the ten-day training programme with a group of 30 participants from a local church. Most of the participants were employed by the church, either as pastors or as pastoral interns. There were also teachers and social workers on the course. The group met once a week for a period of 10 weeks.

Motivation

Four participants attended the course because they wanted to develop counselling centres in schools, both in the suburb as well as in the local township. One participant wanted to start a counselling centre at the local church and is appointed by the fraternal to oversee the family work for the churches. Most of the participants were involved in some kind of counselling and wanted to improve their skills.

Genogram

The participants varied in their responses to the genogram work. For some participants it was enlightening, for others rather complex. For some it was a painful experience. All agreed on its value and how it helped them to see themselves in the context of their family of origin. The participants related well to the contextual and narrative perspectives on their family life. They presented their genograms making use of both 'languages'. They spoke about split-loyalties and how they were never able to please both their parents. They mentioned patterns in their family history of illness or substance abuse. They also spoke of dominant stories of being rejected by the family of origin and finding strength and hope in memories of childhood resilience and being enabled to engage in trustworthy relationships.

The mental health problems were presented by the researcher and lively discussed by the groups. Often differently contextualized by African participants and by many experienced as part of lived family life.

The case design and role plays were prepared collectively, drawing on the notes in the manual, discussing their dynamics, applying the contextual and narrative understanding to the mental health problems that were part of the case. These perspectives throw a different light on the understanding about the origin and experience of the condition and create more awareness of the need for families to receive counselling. The role plays themselves were staged with enthusiasm and apprehension. Participants wondered: "Are we able to portray the roles we've defined and discussed with the complexity of the family dynamics? The counsellor wondering if they would be able to practice multi partiality and received much encouragement from the group as well as critique, which was constructive. The therapist challenged the participants to explored more, she called the people back to gain more insight and to try again, all aimed at providing informed and insightful counselling. The need for de-role-ing afterwards as otherwise you look at the participant and really think he is the authoritative and money minded father. Though now that you've heard the man speak and understand more of the culture that informed his thinking, you can place his story next to that of the other members of the family.

5.5.2.3 The Third Pilot Course

The researcher conducted the five-day training programme with a group of 25 participants who represented 18 different faith based organisations in Swaziland.

Motivation

Because all participants are practically involved in HIV/AIDS related work, they were highly motivated to attend the course. All participants were expected to report back to their organisations and fill their colleagues in on information received.

Genogram

The participants enjoyed the genogram work, and welcomed the new tool in depicting family life. They created other entries, as although Mcvean et al (2001) adjusted the official standard of the genogram, the situation of belonging to a family of 46 children was

not in their books. One participant stated during lunchtime that she would not get married in a hurry and invited debate on the topic. During the week she struggled doing her genogram and said to feel shame about the construct of her family as the dominant story that she lived was not what she really wanted for her life. The contextual concepts of reciprocity and fairness were hard to apply to her picture. On the last day of the course she volunteered unexpectedly to demonstrate her genogram and the researcher helped her discover and name the unique moments, the events visible in the genogram and contrary to her storyline. She mentioned that for her the week had been a healing experience and that she would continue to work with what she had gained. Other participants mentioned that a week long programme about bereavement and trauma, even when it provides information and skills, becomes heavy. "We are not concentrating at times, because we think of our families at home and recognise so much of what you are bringing to our attention". This comment made de therapist aware of the role of humour in counselling and she decided in the final design to add more humour and relaxation exercises. The participants designed case studies and performed these in trio's. The researcher asked the observers to comment and explored the counselling dynamics. Many trio's brought in their personal stories and experiences. The researcher experienced the dilemma that participants were 'told what to believe' e.g. the representative of the royal family, mentioned in his opening speech that "children were not to attend funerals, because seeing a corpse would make them into people that are killers". This authoritative discourse would make people believe in myths. The participants asked the researcher for more training pertaining to children who are grieving and creative ways of helping them to grieve. Much of their work is related to OVC and they welcome skills to help these children deal with trauma and losses in life.

5.5.2.4 Ongoing assessment of adequacy of the training programme

Ongoing assessment of adequacy of the training programme was done by the researcher throughout the pilot courses in collaboration with the course participants (co-researchers). Many aspects of the programme were immediately assessed. The researcher made field notes of informal evaluation

5.6. Step Five: evaluation and advanced development of the Intervention Research Model as adapted from De Vos (2001:385)

This part of the training development demonstrates how the training impacts on participants and results in changed behaviour, both for the participants and their area of influence.

5.6.1 The experimental design was selected.

In all three pilot studies, the genogram work showed how participants engaged with the work on their families of origin and became more attached with their family identities. The combination of contextual and narrative work was complementary, which refers back to the coming together of the hermeneutic and social constructionist paradigm, as mentioned by Freedman and Combs (1996). For the participants this was a realistic and often painful as well as hopeful and rewarding experience. After the training the researcher received the response that the training had changed their thinking and therefore their actions towards clients. Specifically on the second pilot study participants would say: "I learned first to listen and to think and listened more to understand better". Although the course was hard work and experienced as "being involved', the participants managed to grow from each aspect, be it the theory, the devotional time, the presentations and the discussions. Growth was experienced in personal development and the quality of the presented counselling exercises. This process of narrative learning was derived from Freeman et al (1991).

5.6.2 Instructions and Manuals were further developed, tested and revised.

The Course Instruction and Reader from the first pilot study was further developed and will be used for training at Bible Colleges.

The Course Outline and Course Manual from the second pilot study, was further developed and will be used for the Module in family mental health/ psycho social counselling.

The Course Outline and Manual from the third pilot study, was further developed and will be used for the Module in bereavement and trauma counselling.

The researcher decided in collaboration with the participants that the final design of the Pastoral Family Therapeutic Counselling Course would consist of three Modules, the

- 5-day Module in family bereavement and trauma counselling.
- 5-day Module in family mental health/ psycho social counselling.
- 5-day Module in OVC counselling and play therapy skills.

All three Modules would incorporate contextual and narrative family therapy skills training.

The Post-foundational Practical Theology Model has been utilized in preparing the design, the implementation and development of the training manuals. As mentioned in Chapter two, this Model is consistent with the IRM and provided a frame work that enabled the researcher to remain consistent with a hermeneutic and social constructionist perspective. The training was concerned with descriptions of specific contexts, in-context experiences, interpretations of these experiences, new descriptions and developed understanding. This work was informed by the literature study and the outcome of the field work and further developed with the 'co-researchers' the participants on the different courses. The reflection on God's presence was experienced throughout the courses. This could take the form of encouraging text, or critiquing prevailing dominant discourses by participants. Communal prayer and song were also expressions of experiencing God's presence. Throughout the research process, the description of experience thickened, as much was described and connected to already shared experience. Specifically the interdisciplinary investigation as described in the literature and experienced at the level of community practice thickened the description of experience. Tradition, culture and cultural discourses provided complimentary understanding of reality (van Huyssteen 1998).

One participant identified a pattern of wife battering and promiscuity in his family of origin. The men were expected to maintain this lifestyle and the women condoned it. The participant realised that this was not what he wanted in marriage and decided to live his preferred story. He discussed the relational ethical considerations and implications with the group.

The second pilot study developed more of the interdisciplinary investigation, as participants represented different fields of study, e.g. social work, education.

5.6.3 A supervisory system was developed to assess trainee competence, personal development and external accountability

The researcher developed a supervisory system to assess counsellors competence within the organisation or Churches where the counsellors are practicing. The researcher developed a plan whereby the counselling rooms or centres are monitored by a 'case manager'. This person would then be responsible for the correct management of client's appointments, counsellor's report writing and would keep a rapport with the counsellors. An ecosystemic approach would include collaborative relationships with families and communities. Families would become partners in resource development (Pulleyblank Coffey, 2004). The counsellors would engage in an ongoing programme of personal and group supervision. The researcher made use of the evaluation form developed by Flemons et al (1996). This device was developed from a social constructionist perspective on supervision and is using narrative and relational ethical methodology (Flemons et al 1996).

5.7 Step Six: dissemination of the Intervention Research Model as adapted from De Vos (2001:385)

The training programme has been prepared for dissemination. A name was decided on and the programme is called Ukuphila Komndeni, which means 'Family Life'.

The Ukuphila Komndeni programme was further piloted in 2009.

Other tasks would be to decide on the right price for the training course. It needs to be realised that church leaders are often not well paid by their churches and would not be able to pay large sums of money for a training programme. The researcher has experienced though that to be able to participate on the training course, community members have gone out of their way to make ends meet and attend the training.

Standards and guidelines for the use of the training programme must be set. These standards and guidelines would need to be in line with the Unit Standards and also with the HIV/AIDS and STI National Strategic Plan (Kehler 2007).

The training programme needs to be advertised, e.g. by word of mouth, the media, and presentations for fraternals and churches.

Bible Colleges and seminaries in Southern Africa can be encouraged to adapt and implement the programme.

Other training institutions involved with family therapeutic counselling can be encouraged to adapt and implement the training programme.

This study has been part of the partnership between the Disciplines of Religion and Culture and Social Work at the University of KwaZulu Natal. Several studies were undertaken, pertaining issues of HIV/AIDS. The discipline of Social Work has provided family therapy training to theological students at Masters Level. The graduate students will be approached by the researcher in order to establish partnerships in reaching the communities and families with HIV/AIDS.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 <u>INTRODUCTION</u>

This Chapter presents the Ukuphila Komndeni (family health) training programme, which is the outcome of a culmination of each of the phases and steps of the Intervention Research Model as adapted from De Vos (2001:385); including the

      a) Literature review
      b) State of the art reviews
      c) Field work investigation
      d) Pilot test results

The researcher carefully interacted between the theory as described from the fields of theology, social work and family therapy and the life world of people, organizations and systems living with HIV/AIDS.

- The study was aimed to discern what knowledge, understanding and skills church leaders and lay counsellors need to learn, gain, and practice in order to be better equipped in working together and meeting the needs of families living with HIV/AIDS in their church communities.

- The study set out to explore the nature of personal and relational problems facing a person living with HIV/AIDS, their families and their communities.

- the study explored the role of the Churches in Southern Africa and the nature of family therapeutic services offered by church counsellors to families with HIV/AIDS.

- The study set out to develop a design for training theological educators and church leaders in contextual and narrative family therapeutic counselling skills and piloted this training programme with three separate pilot groups.

- Further the study arrived at a model for pastoral development training and supervision of pastoral family counsellors, working in communities affected by HIV/AIDS

- The study set out to under build this model with relevant theoretical understanding, as discussed within and between the fields of education, social science and theology. Specific emphasis was put to the application of narrative and contextual theory and practice to the training of pastoral family counsellors.

- The Intervention Research Model as adapted from De Vos (2001) was viewed as serving the purposes of this study and the conclusions in respect of the outcome of the study are described under each of the phases of the research, namely the analysis phase, developmental phase and evaluation phase. The conclusions are derived from the literature research in Chapters 3 and 4 as well as from the fieldwork investigations discussed in Chapter 5. This is followed by recommendations.

6.2   THE ANALYSIS PHASE OF THE INTERVENTION RESEARCH MODEL AS ADOPTED FROM DE VOS (2001:385)

During this phase of the study, a literature research was done on the life world of highly affected families, e.g. 'skipped families' and 'families of gay and lesbian HIV infected people, which informed the researcher about the magnitude of the problems, the

personal and communal implications of the pandemic and the obstacles caused by poverty and remaining denial and stigmatization.

The 'state of the art' study, based on narratives of families living with HIV/AIDS, created a broadened perspective on family life and HIV/AIDS as the stories were derived from several African countries and highlighted the cultural implications of HIV infection. Based on these narratives, the researcher specified several themes and discourses and referred to these as relevant to the compilation of training materials.

1. Poverty and HIV
2. Sex & Gender
3. Silence & Denial
4. Bereavement & Trauma
5. Abuse & Violence
6. Church & Theology.
7. Health Care Dominant African Culture
8. Dominant African Culture
9. Community Mobilisation
10. Communication in Families

Further, a literature research was done on the history of churches in Southern Africa. The researcher was informed about the diversity of churches, both in their theological understanding as well as in their way of practice. The researcher felt it necessary to relate back to the Apartheid area, as she described that much of the variety of approaches in Churches towards families living with HIV/AIDS stems from differences in theological understanding, the way Churches are structured as well as how they are embedded in culture and history. The developed variety in worldview was further described from a post modern perspective.

The researcher provided a 'state of the art review' of the role of the churches related to families living with HIV/AIDS. The review described the activities of the different denominations. Many churches are involved in care, counselling and supportive

activities. Critical factors are the cultural taboo on talking about sexuality, specifically in the African initiated Churches and the stigma and discrimination which are found in the churches. There is a need for access to treatment and already mentioned is the vulnerable position of HIV positive and orphaned children. The state of the art also described the role of faith based organizations and their importance in community based work, as they integrate a 'professional service' with a Christian identity.

The researcher described a hermeneutic approach in theology, social science and education in order to compare the philosophical under building of these disciplines and determine how their action fields are informed. In all these fields the integration of a social constructionist view and a hermeneutic view on life are practiced and encouraged. Interdisciplinary conversation is also promoted in post-foundationalism.

The hermeneutic and social constructionist view encourages to find communal truth and develop understanding of the life world of families with HIV/AIDS and provide informed pastoral practice.

The researcher examined literature on hermeneutic narrative theology in order to determine the action field of the pastoral family counsellor in the context of church and community. In this discussion, the identity formation and counselling role of the pastoral family counsellor came to the fore.

The researcher also mentioned a hermeneutical dialogical perspective to the counselling relationship, which relates to the narrative of God, the counsellor and the client.

The researcher looked at hermeneutics in social work in order to describe the dialectic process and connect the field of social science with the field of theology.

Further the researcher discussed literature on the practice of social work related to families with HIV/AIDS and described an approach based on social constructionist theory.

The combination of the hermeneutic (self) reflective approach and the social constructionist approach provide the reach that social workers have both in individual

and community work. The researcher expressed the need for pastoral counsellors to take on some of these counselling roles.

The researcher described the practice of narrative and contextual counselling as relevant for families with HIV/AIDS, as both approaches to therapy relate to destigmatizing of HIV/AIDS and people being enabled to live their 'preferred' lives.

The importance of family values is described, as found in relational ethics, which enrich family life and can be consolidated in the counselling process.

In Chapter four, the researcher described a hermeneutic approach to learning and related this to the educative process of evidence based learning.

She described the relevance of the evidence based approach to learning for family therapy and pastoral counselling training. Relevance would be the right choice of therapeutic method, in collaboration with the client and therefore a greater understanding of the social, cultural, political and spiritual life world of the client.

The researcher examined alternative models of programme development, in comparison to the Intervention Research Model. Systemic models do provide an accurate and comprehensive approach, but a transformative approach to learning focuses on the person of the counsellor instead of merely on the 'right' performance of counselling skills.

The researcher focused on the assessment of learner competence and would:

- value and show respect for the church leaders own prior knowledge and build on this knowledge and experience
- establish counselling competencies with the learners
- interview prospective trainees, in order to assess trainees motivation and capacities
- design a programme of ongoing training, assessment and supervision

- carefully select assessment tools that enhance the knowledge base and help reflect on counselling competence

- establish community based counselling and training rooms that are coordinated by a placement manager

- combine moderate hermeneutics and critical hermeneutics

- create a therapeutic alliance with the participant and with the group

- encourage transparency, reflection and openness in the supervisory relationship

- prefer to work with one way screens, as they make it possible for a team to be part of and contribute to the learning experience

- develop 'problem ethnography's' into case studies to be used for training and group discussion

- provide a 'containing' environment in supervision, where participants can deal with their own life situations and can be helped by their peers

- be attentive to the lifestyle of the participants and build the aspect 'self care' in the programme

The second 'state of the art' study was on existing training programmes for pastoral family counsellors.

The researcher did an internet search on family therapeutic counselling skills for church leaders and lay counsellors. There was no result which encompassed all entries.

The researcher visited two schools for family therapy in the Netherlands in 2005 that provide contextual family therapeutic counselling to church leaders and lay counsellors.

The researcher updated her information about these training facilities through an internet search. The researcher incorporated the focus on relational ethics and therefore strength based family therapeutic counselling in the training design.

The second part of the Analyses Phase relates to the field work investigation.

The field research is presented under the operational steps one and two of the Intervention Research Model as adapted from De Vos (2001:385).

In-depths interviews with five members of an HIV/AIDS support group, focussing on the life world of a person living with HIV/AIDS (5.3.1).

The themes and discourses that derived from the interviews informed the researcher about the reality of

- living with adversity and the reality of living with 'scars'
- the victimization of sick people, specifically when there is no hope for recovery
- the feelings of loneliness that non disclosure can cause
- the discourse of a homophobic environment
- the discourse of the power of the virus as a determinant for behaviour
- diverse perspectives on the role of God, as healer and punisher

The researcher became aware of the importance of support groups and that support groups would need to be supplementary to family counselling services as unique opportunities to meet with other HIV infected people.

The survey with 100 church leaders and lay counsellors in the study aimed to provide a 'state of the art review' of the life of the churches in the greater Durban area (5.3.2).

The researcher gained the following from the outcome of the study

The result of the HIV/AIDS related activities of the 100 churches as mentioned in the study was encouraging, realising how much community based education, counselling, care and development work is undertaken through the local churches. As noted before, these are biased results and are not indicative of all churches in KwaZulu Natal. These are churches where trained people put activities in place and helped their churches think through issues of HIV/AIDS.

Questionnaire interviews with 50 church leaders and lay counsellors
The questionnaire interviews with 50 church leaders and lay counsellors in the study aimed to provide a 'state of the art review' of the counselling practice of the churches in the greater Durban area (5.3.3).

The researcher gained the following from the outcome of the study:

The result of the counselling practice of the 50 churches as mentioned in the study seemed encouraging. Also in this study, the results are biased, as the reflection was done by trained counsellors. The participants requested more professional counsellors in all five areas and do recognise the need for family counsellors, specifically related to ART adherence. The training and supervision of church leaders and the provision of a local counselling facility will fulfil that need. The stratification did not show much of a difference in outcome between the areas, except that in the rural and semi-rural areas condom use remains problematic within marriage relationships.

The ten focus group interviews in the study aimed at community counsellors and concerned with the problems that families face in the communities and with the role of the churches related to HIV/AIDS (5.3.4).

The researcher gained the following from the outcome of the study.

Families in the communities that were researched are faced with a multitude of complicated problems, e.g. poverty, death, stigma, substance abuse, child neglect, crime. In most of these families sexuality is a topic that cannot be discussed in the

home. Generally there is a lack of communication in the homes. Counsellors have good intentions but are sometimes rejected by the community, because they come across as inquisitive.

Solutions and suggestions that came from the participants were: information workshops, training in parenting skills, programmes for youth and sexuality, contextual preaching, for people to speak openly about their status and more trained counsellors.

All these suggestions fit the scope of the training programme and are encouraging in the context that they will resolve some of the mentioned problems.

The three focus groups in the study aimed at church leaders. Focus group interviews were performed to generate data regarding the church leader's perceptions of the need and provision for family counselling services in their communities (5.3.5).

The researcher gained the following from the outcome of the study

The church leaders mentioned the following constraints:

Many of them do not feel equipped to counsel in problems of mental health, they perceive a lack of training and find that people with problems approach them at a very late stage, e.g. when they have filed for divorce. They also miss the church community volunteering, as nowadays people go away on the weekends.

Solutions and suggestions that came from the pastors were: to develop resources, provide preventative and community based programmes, develop relationships of trust with people in need of counselling, to be involved in the planning of training.
The church leaders embraced the prospect of family therapeutic counselling and relate the value directly to their practice.

Questionnaire interviews with 36 church leaders (at the time being trained by Siyahlanganisa centre) related to the outcome of their training (5.3.6).

As mentioned in the study, these church leaders were highly motivated to become active in their churches related to HIV/AIDS. Their counselling practice entails HIV/AIDS, poverty related counselling, substance abuse, dysfunctional families, domestic violence, depression, suicide, teenage rebellion, incest and divorce.

Many pastors did not receive information, nor training, on how to approach people with these problems in counselling.

6.3 THE DEVELOPMENT PHASE OF THE INTERVENTION RESEARCH MODEL AS ADOPTED FROM DE VOS (2001:385)

The overall outcome of the Analysis Phase is that there is a need for a training programme in family therapeutic counselling skills for church leaders and lay counsellors. Families living with HIV/AIDS have multiple problems. According to the outcome of the field research there is a need for more professional counsellors to deal with these problems. The literature research has shown that narrative and contextual family therapy are strength based approaches and that church leaders and lay counsellors would benefit from this particular approach in counselling.

The developmental phase was concerned with the design and implementation of the three pilot studies in family therapeutic counselling for church leaders and lay counsellors.

The researcher found Muller's post-foundational practical theology model useful in designing the actual training manuals. The model accommodated the constant interaction between theory and practice. This process continued during the pilot study,

as the researcher and participants (co-researchers) gained knowledge, insight and practice skills.

The model invited God's presence as a relational Partner, which was highly appreciated by all participants.

The researcher found that the genogram work, the case study design and the role plays became the main assessment tools. The researcher made also use of other assessment tools, e.g. written examinations.

The outcome of the study was two course designs.

The initial course design is a combination of training in contextual and narrative therapy combined with training in psycho social counselling.

The second course design is a combination of training in contextual and narrative therapy with training in bereavement and trauma counselling.

Both courses were designed for five days and can be conducted as one training course. HIV/AIDS and poverty are mainstreamed in both training courses.

Conclusions.

The ukuphila komndeni programme contains two courses in pastoral family therapeutic counselling, based on contextual and narrative therapy. The courses are aimed for church leaders and lay counsellors, who provide pastoral counselling to families with HIV/AIDS. The courses provide training in psycho social /mental health problems and in bereavement and trauma.

6.4 __RECOMMENDATIONS__

The researcher combined the evaluation phase of the Intervention Research Model as adapted from De Vos (2001:385) with the recommendations.

The ukuphila komndeni programme was piloted with 3 separate groups of church leaders, lay counsellors and FBOs. The courses were well received and seemed relevant to the particular contexts of the course participants.

Families with HIV/AIDS are in need of knowledgeable and capable counsellors. Already many churches have counselling teams in place, as churches reach out into the communities and more counsellors are needed to help families deal with the problems that they face.

The training in psycho social/mental health problems is important, as we have seen that many mental health problems are not identified in the communities and people are not getting referred for treatment. Churches are starting VCT sites and become active in ART support. Therefore training in psycho social assessment is important, in order to test for ART readiness.

Training in bereavement counselling in a time of AIDS is a necessity for church leaders. People still die young and families are left dealing with multiple losses. People in communities become traumatized because of violence and crime and develop post traumatic stress.

The pilot group in Swaziland asked for further counselling training in working with bereaved and traumatized children and also for training in relationship counselling.
Both courses are relevant for pastoral family counsellors and will be added to the programme of Siyahlanganisa Centre

At Micro level

The training programme can be promoted to church organisations and fraternals and the family counselling programme would be performed at the churches.

At Mezzo level

The training organisation and the churches would develop pathways, in order to provide family counselling at the church based counselling centre, at schools, hospitals and the local police stations.

At Macro level

The developed training programme can be incorporated within the government's HIV & AIDS and STI National Strategic Plan in HIV Treatment, Care and Support and help in mitigating the impact of HIV/AIDS in families. The researcher would collaborate with the Department of Social Development and the Department of Education.

Counselling Centres

The training organisation would organise counselling centres within different communities. The centres would need to be coordinated by a placement manager, who would be responsible for the running of the rooms. The drop in centres as organised by the government may well benefit from an added service in pastoral family therapeutic counselling.

Supervisory system

The training centre would provide supervision for beginning family counsellors and develop a programme of group supervision and refresher training. The counselling practice needs accountability and report writing is a basic counselling skill. The counselling rooms may also be part of a church or a community centre, which provides an organisational structure. The provision of counselling can be combined with community education, and community outreach. At the same time it will be important to keep the counselling in focus.

KwaZulu Natal

The training centre will need to train facilitators for this particular programme, who are knowledgeable and skilled in pastoral family counselling. The programme can be trained provincially or nationally. The reach will depend on available funding and on the need for training in other provinces.

Bible Colleges

The training centre will promote the programme at several Bible Colleges. The courses would be presented as electives and provided after the students have finalised their basic and advanced counselling training. Most likely that would be in their second or third year of training.

Further Research

Research can be undertaken in the different communities, to assess the functioning of the counselling centres and the evaluative system and derive at a model for best community practice.

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275

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A.1. Survey with course attendants (church leaders and lay-counsellors at the time being trained by Siyahlanganisa Centre) providing a profile of church life 5.3.2.

The survey included the following questions.

1. About Care Structures in your church.
   a. Does your church have an HIV/AIDS support/care team?
      If yes,
      i. How many people are in the team?
      ii. How often do you meet?
      iii. Does your church have an HIV-policy?
      If no,
      i. Who coordinates the HIV/AIDS work in your church?
      ii. Who communicates with the different church departments about the problems that HIV/AIDS brings to the church?

2. About prevention, support and care.
   a. Does your church provide information to people about HIV/AIDS?
      i. Have you provided written information, e.g. pamphlets?
      ii. Does your church provide individual counselling on HIV/AIDS??
      iii. Does your church organise information meetings for church groups?
      iv. What were the topics you discussed?
      If no,
      i. What kept your church from providing information?
   b. Have you provided spiritual support to HIV-positive people? If your answer is yes, what type of support do you provide?
   c. How has your church helped people to do any of the following?
      i. Find out their HIV-status?

ii. Find out their CD4-count?

iii. Apply for antiretroviral treatment?

iv. Apply for grants and benefits?

d. Has your church referred anyone to community service providers?

e. Has your church referred anyone to income generating projects?

f. Has your church supported anyone in taking antiretroviral treatment?

3. About Children.

a. Does your church have a children and youth ministry?

b. Have your youth leaders received training on HIV/AIDS?

c. What care programs does your (church) community have in place for HIV-positive children?

d. What care program does your church have in place for orphaned children?

4. About Counselling.

a. What are the topics discussed during pastoral counselling to HIV-positive people and their families (should such counselling happen)?

b. Is counselling provided at another venue. E.g. a police station, prison, hospital? What type of problems are presented to the counsellors?

5. About Support Groups.

a. Are there any support groups for HIV-positive people in your (church) community?

If yes,

i. Who is the facilitator (person/organisation)?

ii. Where are the meetings held?

iii. Average number of participants?

iv. Have the participants disclosed their status?

      v. If the group is doing income generation, what do they produce?

      vi. Where do they sell their goods?

    If no,

      i. Do you see the need for a support group in your area?

6. About projects.

    a. Is your church involved in any of the following projects?

      i. Income-generating project

      ii. VCT-site

      iii. Orphan Care Project

      iv. Community Education Project

      v. Hospice or Day-Care Project

      vi. Feeding Project

      vii. Other Projects...

    b. If your answer is yes to any of the above, please provide the following information:

      i. Name project

      ii. Address project

      iii. Name project manager

      iv. Main purpose of project

    c. Did your church fundraise for any project?

7. About Psycho-Social/Mental Health problems

    a. What are the main psycho-social/mental health problems that your (church) community is dealing with?

    b. Is your church providing information about these problems?

    c. Is your church providing counselling services to people who are dealing with psycho-social/mental health problems?

    d. What type of service is provided?

8. About your church.

  a. Does your pastor preach on topics related to HIV/AIDS?

  b. Do people in your church speak openly about HIV/AIDS?

  c. Are HIV-positive people welcome in your church?

  d. Have HIV-positive people disclosed their status in your church?

  e. In what way does your church support church members in the activities they are involved in?

  f. How would you like your church to support you?

9. Other topics.

  a. Is there anything else you would like to mention?

A.2. Study on family counselling in churches with 50 participants from churches within the greater Durban area (2006-2007), focusing on different types of areas, including community profile 5.3.3.

The questionnaire part included the following questions:

1. Do you consider counselling service to be an essential part of the ministry of your church? Please give reasons for your response.

2. Does your church provide counselling to members only, or also to non-members of the church? Please give reasons for your response.

3. What are the most common problems that families are presenting to church counsellors?

4. Who offers counselling services in your church? Please indicate the number of counsellors and the specified areas of counselling they are involved in.

5. How many families come to your church for counselling approximately per month? How many of these families have HIV/AIDS related problems?

6. Do the church counsellors provide counselling services to families affected by HIV/AIDS? If yes, please specify the nature of the services rendered and whether they perform home visits?

7. What are some of the problems that families affected with HIV/AIDS discuss with their counsellors?

8. In what ways have counselees benefitted from the counselling services provided?

9. Do churches refer families to other counselling providers in the community? Please give reasons for your response.

10. Which agencies in your community provide counselling services to families living with HIV/AIDS?

11. Do your church counsellors recognise a need for additional training in family counselling? Please give reasons for your response.

12. Is there any additional information that you want to provide?

Participants on the courses were asked to produce a community profile, which some elected to do in groups. They were informed by these profiles, which included information about which facilities and resources are available in the communities; for example, Hospitals, Clinics, NGOs, etc. They also included information about the area's history, politics, demographics, local economics, educational system, housing and sanitation, and sometimes the policies and procedures of any government agencies (police stations, welfare institutions, etc.) in the community; as well as about the main problems in the community.

A.3. Questions to Church Leaders attending The HIV/AIDS Advanced Community Counselling Course for Church Leaders and Lay-Counsellors, given by The Siyahlanganisa Centre 5.3.6.

1. Are you leaving [the course] with fresh ideas of how to take the next steps in addressing HIV in your ministry?

2. Are there challenges for the future in which you would like more support?

A.4. Course Training Outline (3 Programmes).

A.4.1. Pilot Study 1: Contextual & Narrative Family Therapy Skills Training

A.4.1.1. Course Outline:

Year	2006	TERM	1	Third Year	For Official Use Only	
1.Course Title		**Contextual & Narrative Family Therapy Skills Training**			**Approved by Principal**	
					Date:	
2.Course Code		**160 notional hours (16 Credits)**			**Signature:**	
3.Course Description:					**Revised:**	
Introduction to contextual, narrative and spiritual family therapy and the development of counselling skills in the areas of abuse, chronic illness, depression, parenting, eating disorders.						
4. Learning Outcomes						
Know: Gain insight in a contextual, narrative and spiritual approach to working with families in South Africa.						
Be : A knowledgeable, skilled, kind and prayerful counsellor						
Do : Apply counselling skills to help families with problems.						
5. Assessment Criteria						
Mid-term Test (wed, fri, wed – 5% + 10% + 5%)						**20%**
Final Test						**25%**
Research Paper						**15%**
Reading Report						**5%**
Role-play (4@ 5%)						**20%**
Attendance & Punctuality (5%) & Attitude Change 5%						**10%**
Seminar Presentation: Max 10 minutes (research)						**5%**
Class list and topics of research						
6. Assessments:						
6.1. Term Paper: Discuss the ethical dimension in human relationships and provide examples from your family of origin. **(Due: end of March)**						
6.2. Role-Play: You are to role-play a counselling session with a family. You are the counsellor that is attempting to counsel a family with one of the following problems. The facilitator will assign one of the problems to you at random.						
6.2.1 **Abuse, chronic illness, depression, parenting, eating disorders.**						
7. Learning Programme - The learner will be able to -						
W	**L**	**Learning Session Outcome**			**Methods**	**Min**

1					
M O N D A Y	1	**Orientation** - Practice spiritual discipline - Know the content and purpose of the genogram - Acquire skills in making genograms - Gain insight in personal family history - Gain understanding of the problem of abuse - Discuss the contextual and narrative approach to families dealing with abuse - Design a case study - Gain skills in team work - Engage in family counselling - Assess the counselling session	Meditation Lecture Practical Application Lecture Class discussion Case Design Role Play Evaluation *Nasimiyu-Wasike p.120-135* *Stevens p.105-121* *Kamsler p.47-74* *Greunen p. 99-112* *Total p.71.*	30 60 60 60 60 60 60 30	
T U E S D A Y	2	- Practice spiritual discipline - Understand basic concepts of contextual family therapy - Application of basic concepts to own family genogram - Gain insight in personal family history - Gain understanding of the challenges of chronic illness -Discuss the contextual and narrative approach to families dealing with chronic illness - Design a case study - Acquire skills in role taking - Engage in family counselling - Assess the counselling session	Meditation Lecture Practical Application Lecture Class discussion Case Design Role Play Evaluation *Beckvar p. 168-174* *Fennell p. 28- 44* *Fennell p. 184-189* *Ncube p. 78-107* *Weingarten p. 13-24* *Grobbelaar p. 81-96* *Total p.82.*	30 60 60 60 60 60 60 30	

W **E** **D** **N** **E** **S** **D** **A** **Y**	**3**	- Practice spiritual discipline - Understand therapeutic strategies and interventions of contextual family therapy - Application of basic concepts, strategies and interventions to own church community - Gain understanding of the problem of depression - Discuss the contextual and narrative approach to families dealing with depression - Design a case study - Acquire skills in focusing on the ethical dimension - Engage in family counselling - Assess the counselling session	Meditation Lecture Practical Application Lecture Class discussion Case Design Role Play Test *Soyez p. 286-302* *Hibbs p. 109-131* *Minirth & Meier p. 23-29* *Swartz p. 97-120* *Fuller-Good p. 77-95* *Hudson p. 269- 288* *Total p. 105*	30 60 60 60 60 60 60 30
T **H** **U** **R** **S** **D** **A** **Y**	**4**	- Practice spiritual discipline - Understand family systems theory - Application of family systems theory to own family of origin - Gain understanding of the challenges of parenting - Discuss the contextual and narrative approach to parenting skills - Design a case study - Engage in family counselling - Assess the counselling session	Meditation Lecture Practical Application Lecture Class discussion Case Design Role Play Evaluation *Balswick & Balswick p. 37-53* *Balswick & Piper p.167- 175* *Hendriks, p.71-100* *Brown- Standridge p. 185-196* *Basson p. 15-29* *Total p. 78*	30 60 60 60 60 60 60 30
F **R** **I** **D** **A** **Y**	**5**	- Practice spiritual discipline - Gain understanding of the basic principles of narrative family therapy - Application of story telling - Gain understanding of the problem of eating disorders - Discuss the contextual and narrative approach to families dealing with eating disorders - Design a case study - Engage in family counselling - Assess the counselling session	Meditation Lecture Practical Application Lecture Class discussion Case Design Role Play Test *Beckvar p. 291-295* *Minirth p. 52- 66* *Kraner p. 91- 114* *Total p. 42*	30 60 60 60 60 60 60 30

M O N D A Y	6	- Practice spiritual discipline
		- Gain understanding of the concept of externalising a conversation
		- Identify examples of externalising conversations in your (church) community
		- Research literature and give a 10 minute seminar presentation on the problem of abuse
		- Group assessment of presentation
		- Design a case study
		  Engage in family counselling
		  Assess the counselling session
			Meditation
			Lecture
			Practical Application
			Lecture
			Class discussion
			Case Design
			Role Play
			Evaluation
			
			Russel p. 3-16
			Total p. 13
				30
				60
				60
				60
				60
				60
				60
				30

T U E S D A Y	7	- Practice spiritual discipline - Gain understanding of the concept of re-authoring a conversation - Identify examples of re-authoring conversations in your (church) community - Research literature and give a 10 minute seminar presentation on the challenges of chronic illness - Group assessment of presentation - Design a case study - Engage in family counselling - Assess the counselling session	Meditation Lecture Practical Application Lecture Class discussion Case Design Role Play Evaluation *Russel p. 21- 42* *Total p, 21*	30 60 60 60 60 60 60 30
W E D N E S D A Y	8	- Practice spiritual discipline - Gain understanding of the basic concepts of spirituality in family therapy - Clarify counsellors own attitude, prejudices, vulnerabilities and beliefs - Research literature and give a 10 minute seminar presentation on the problem of depression - Group assessment of presentation - Design a case study - Engage in family counselling - Assess the counselling session	Meditation Lecture Practical Application Lecture Class discussion Case Design Role Play Test Walsh p. 28- 53 Griffith p. 209-221 Wright p. 61- 75 Aponte p. 76- 87 *Total p.64*	30 60 60 60 60 60 60 30

T H U R S D A Y	9	- Practice spiritual discipline
		- Gain understanding of the practice of
		  spirituality in family therapy
		- Application of basic concepts to own
		  spiritual family genogram
		- Research literature and give a 10
		  minute seminar presentation on the
		  challenges of parenting
		- Group assessment of presentation
		- Design a case study
		- Engage in family counselling
		- Assess the counselling session
			Meditation
			Lecture
			Practical Application
			Lecture
			Class discussion
			Case Design
			Role Play
			Evaluation
			
			Wiggins Frame p. 211-216
			Total p.6
				30
				60
				60
				60
				60
				60
				60
				30

F R I D A Y	10	- Practice spiritual discipline
		- Gain understanding of the practice of
		  multiple family work
		- Describe possibilities of multiple
		  family work in own (church)
		  community
		- Research literature and give a 10
		  minute seminar presentation on the
		  problem of eating disorders
		- Group assessment of presentation
			Meditation
			Lecture
			Practical Application
			Lecture
			Class discussion
			Final Test
			Evaluation
			
			Asen p. 3-14
			Total p.11
			Total p. 493
				30
				60
				60
				60
				60
				120
				30

Readings:

1. Balswick, J&J and B&D.Piper. 2003 *Relationship Empowerment Parenting. Building formative and fulfilling relationships with your children.* Baker Books Michigan
2. Balswick, J.O. & J.K.Balswick 2000 *Family. Christian perspective on the contemporary home.* . Baker Books Michigan
3. Bate, S.C. 2003. Ed. *Responsibilities in a time of AIDS. A Pastoral response by catholic theologians and AIDS activists in Southern Africa.* St. Augustine College of South Africa, South Africa
4. Beckvar, D.S.& R.J.Beckvar 2000 *Family Therapy. A Systemic Integration*. Pearson Education Company, Needham Heights, USA
5. Brown-Standridge, M.D. *Healing bittersweet legacies: revisiting contextual family therapy for grandparents raising grandchildren in crisis.* Journal of Marital and Family Therapy. April 2000, Vol. 26 No 2
6. Fennell, P.A. 2001 *The Chronic Illness Workbook Strategies and solutions for taking back your life.* New Harbinger Publications, Inc. USA
7. Hendriks, H. and H. Hunt. 1997. *Giving the love that heals. A guide for parents*. Pocket Books, New York,
8. Kemp, H. van de 1991 Ed. *Family therapy. Christian perspectives.* Baker Book House, Michigan
9. Kotze, D et al. 2002 *Ethical ways of being.* Ethics Alive, Pretoria

10. Kotze, E. and D. Kotze,Gilbert, 2001 ***Telling Narratives. Spellbound Edition.*** Ethics Alive, Pretoria
11. Minirth,F. et al. 1990 ***Love Hunger. Recovery from food addiction.*** Highland Books Guildford, Surrey
12. Minirth, F.B. and Meier, P.D. 1978 ***Happiness is a choice. A Manual on the symptoms, causes and cures of depression.***. Baker Book House, Michigan.
13. Russel, S.& M. Carey. 2004. ***Narrative Therapy. Responding to your questions.*** Dulwich Centre Publications, Adelaide.
14. Soyez, V. et al. ***The implementation of contextual therapy in the therapeutic community for substance abusers: a case study*** Journal of Family Therapy (2004) 26:286-305
15. Swartz, L. 2002. Ed.***Culture and mental health. A southern African view.*** Oxford University Press, Oxford
16. Stevens, B. 1994. ***Setting captives free. Models for individual, marital and group counselling.*** Harper Collins Publishers, London
17. Walsh, F. Ed. 2003. ***Spiritual Resources in Family Therapy.*** The Guilford Press, New York
18. Waruta, D.W. and H.W. Kinoti 2000 ***Pastoral Care in African Christianity. Challinging essays in pastoral theology***. Action Publishers, Nairobi
19. White,C. & D.Denborough 1998. ***Introducing Narrative Therapy. A collection of practice-based writings*** Dulwich Centre Publications, Adelaide.
20. Wingard B. 1999. ***Telling our stories in ways that make us stronger in Narrative and Community Work*** A Conference Collection. Dulwich Centre Publications, Adelaide
21. Wiggins Frame, M. ***The Spiritual Genogram in Family Therapy.*** Journal of Marital and Family Therapy April 2000, Vol.26, No 2
22. Asen E. ***Multiple family therapy: an overview*** Journal of Family Therapy (2002) 24

Contextual & Narrative Family Therapy Skills Training

Mid-term Test 1 (5%)   **40 minutes**

Provide the right answer:

1. The genogram is: a. a graphic picture of the family
                          b. a technique of asking questions
                          c. a book about the family

2. The genogram is: a. multi generational
                          b. about one person
                          c. a record of mental health problems

3. Contextual family therapy deals with the following concepts: a. loyalty
                                                                      b. spirituality
                                                                      c. power

4. Domestic violence   a. only happens in poor homes
                          b. only happens when partners physically abuse each other
                          c. happens between men, women and children

5. Domestic violence   a. only a certain type of woman/man gets abused
                          b. abuse is a private, family problem
                          c. there is no excuse for abuse

6. Being HIV   a. does not affect the people around you
                  b. means that you need assessment and treatment when you get ill
                  c. means that you regularly need to check your CD4-count

Answer three out of the five following questions:

1.   Give examples of how offenders of domestic violence will keep victims in their role.

2.   If a victim of domestic violence would contact you and ask for help, what kind of counselling support would you provide?

3.   Explain the purpose and the content of the genogram.

4.   Explain the basic concepts of contextual family therapy.

5.   Explain the phase model as described in the chronic illness workbook.

Mid-term Test 2 (5%)　　　　　　　　**40 minutes**

Provide the right answer:

1. Major symptoms of depression are:　　a. moodiness
　　　　　　　　　　　　　　　　　　　b. business
　　　　　　　　　　　　　　　　　　　c. story writing

2. People dealing with depression are:　a. feeling hopeless and helpless a good part of the time
　　　　　　　　　　　　　　　　　　　b. having a good appetite
　　　　　　　　　　　　　　　　　　　c. not worried about the past

3. Externalization means　　　　　　　a. to have an 'out of body' experience
　　　　　　　　　　　　　　　　　　　b. to meet family members separate for counseling
　　　　　　　　　　　　　　　　　　　c. to separate the problem from the person

4. Relative influence questions　　　　a. map the influence of the problems in the client's life
　　　　　　　　　　　　　　　　　　　b. map the unique outcome in the client's life
　　　　　　　　　　　　　　　　　　　c. map the normative stories of the client's life

5. The narrative approach　　　　　　　a. emphasizes health and nurturing of positive change
　　　　　　　　　　　　　　　　　　　b. wants families to role play
　　　　　　　　　　　　　　　　　　　c. speaks about entitlement and loyalty

Answer three out of the five following questions:

1.　　　Describe three major symptoms of depression.

2.　　　Why do you think depression 'was overlooked' in African countries?

3.　　　How can women that are controlled by their husbands be enabled to take charge of their own lives? (use the 'undoing the power of the dominant story' and 'unique outcome' in your answer).

4.　　　Describe the practice of externalization in narrative family therapy.

5.　　　What is the benefit of writing letters to clients after the therapy session?

Mid-term Test 3 (5%)   **40 minutes**

Provide the right answer:

1. Cohesion in a family means: a. a family gathering
                                         b. disengagement
                                         c. degree of emotional closeness

2. Developmental task for the family   a. adjust to marital roles
    with adolescents is to: b. go on a family holiday
                                         c. increase flexibility in family system

3. Projection in parenting means that   a. the child becomes irresponsible or selfish
                                         b. the parent assigns to the child unacceptable
                                            traits or behaviours
                                         c. the child denies a part of him-or herself

4. Unique outcomes are: a. moments when the influence of the problem
                                            has not been so strong
                                         b. special people
                                         c. consequences of choices

5. Narrative family therapy   a. provides a quick fix in helping families
                                        b. provides advice to families in need
                                        c. helps a client build an alternative story

Answer three out of the five following questions:

6.   Describe some of the fundamental concepts of family systems theory

7.   Describe three stages in the developmental life of the family and the major
        tasks in each of these stages

8.   Describe the contextual family therapy approach applied to grandparents
        raising grand children

9.   What is the aim of externalizing in narrative family therapy?

10.   Give examples of preferred stories in the context of re-authoring
        conversations.

A.4.2. Pilot Study 2: Advanced Family Counselling Training

A 4.2.1. Course Outline

SIYAHLANGANISA ADVANCED FAMILY COUNSELLING COURSE DAY 1-5

Time	12/02	19/02	26/02	04/03	11/03
6:30	Devotional	Devotional	Devotional	Devotional	Devotional
6:45	Registration/ course expectations/ introduction of participants	Ice-breaker: family personalities: heroes & clowns	Ice- breaker: family relationships: thick & thin	Ice- breaker: family context: memories & treasures	Ice- breaker: family legacies: precepts & intentions
7:15	Content & purpose of the genogram (presentation)	Psychological make-up of the family (presentation)	Family systems theory (presentation)	Contextual concepts In family counselling (presentation)	Contextual concepts In family counselling (continued) (presentation)
7:45	Acquired skills in making a genogram Personal family history	Application to personal family genogram	Application to personal family genogram	Application to personal family genogram	Application to personal family genogram
8:15	Teenage pregnancy (presentation)	Chronic illness HIV/AIDS (presentation)	Domestic violence (presentation)	Bereavement (presentation)	Substance abuse (presentation)
8:45	Family counselling in teenage pregnancy Case study (group discussion)	Family counselling in chronic illness Case study HIV/AIDS (group discussion)	Family counselling in domestic violence Case study (group discussion)	Family counselling in bereavement Case study group discussion)	Family counselling in substance abuse Case study (group discussion)
9:15	Evaluation & Prayer	Evaluation & Prayer	Evaluation & Prayer	Evaluation & Prayer	Evaluation & Prayer

SIYAHLANGANISA ADVANCED FAMILY COUNSELLING COURSE DAY 6-10

Time	18/03	25/03	01/04	08/04	15/04
6:30	Devotional	Devotional	Devotional	Devotional	Devotional
6:45	Ice-breaker: family narrative: images & meanings	Ice-breaker: family stories: moving moments	Ice- breaker : family beliefs: hopes & dreams	Ice- breaker: family life: joy & sadness	Ice- breaker: family witnessing: shared identities
7:15	Narrative concepts In family counselling (presentation)	Narrative concepts in family counselling (continued) (presentation)	The spiritual genogram (presentation)	The church as a multigenerational relational system (presentation)	Presentations genograms
7:45	Application to personal family genogram	Application to personal family genogram	Acquire skills in making a spiritual genogram	Application to church family genogram	Presentations genograms
8:15	Depression (presentation)	Eating disorders (presentation)	Self mutilation & suicidal ideation (presentation)	Poverty & unemployment (presentation)	Community violence & trauma (presentation)
8:45	Family counselling in depression Case study (group discussion)	Family counselling in eating disorders Case study (group discussion)	Family counselling in self mutilation & suicidal ideation Case study (group discussion)	Family counselling in poverty & unemployment Case study (group discussion)	Family counselling in community violence & trauma Case study (group discussion)
9:15	Evaluation & Prayer	Evaluation & Prayer	Evaluation & Prayer	Evaluation & Prayer	Evaluation & Prayer

SIYAHLANGANISA ADVANCED FAMILY COUNSELLING COURSE PRACTICALS

Time:	01/03	08/03	05/04
09:00 - 09:15	Meditation	Meditation	Meditation
09:15 - 10:15	Administration in counselling	Debriefing in counselling	Written examination
10:15 - 11:15	Role - Play : family counselling	Role - Play : family counselling	Role - Play : family counselling
11:15 - 12:00	Evaluation & Prayer	Evaluation & Prayer	Evaluation & Prayer

A 4.2.2. Assessment

Siyahlanganisa Centre
Advanced Family Counselling Course
Name:_____

Provide the right answer:

1. The genogram is

    a. a graphic picture of the family
    b. a technique of asking questions
    c. a book about the family

2. The genogram is:

    a. multi generational
    b. about one person
    c. a record of mental health problems

3. Relational ethics deals with issues of:

    a. entitlement
    b. age
    c. possession

4. Multi partiality in counselling means

    a. for family members to say one sentence each
    b. for family members to speak their heart
    c. for the counsellor to side with each family member

5. The revolving slate means

    a. unresolved family issues passed to the next generation
    b. valuable family possessions
    c. list of achievements in families

6. Narrative family counselling

    a. emphasizes health and living the preferred story
    b. wants families to role play
    c. speaks about entitlement and loyalty

7. Externalization means

    a. to have an 'out of body' experience
    b. to meet with family members separate for counselling
    c. to separate the problem from the person

8. Re-membering means

    a. to write an accurate report of a counselling session
    b. to map the unique outcome in the person's life
    c. to assess the influence of others in the person's life

A 4.2.3. Assessment

Siyahlanganisa Centre
Advanced Family Counselling Course
Name:_____

Design a case study based on option A or B.
You can make use of:
- **Your own genogram**
- **One of the two cases prepared by the participants**
- **A new case design**

Option A:

Based on the information about any of the presented mental health problems as discussed during the course, (e.g. domestic abuse, chronic illness) design a case study based on the following headings:

- **Dimension of facts**
- **Dimension of individual psychology**
- **Dimension of transactional patterns**
- **Dimension of relational ethics**

Discuss the technique of multi partiality in family counselling related to this case.

Option B:

Based on the information about any of the presented mental health problems as discussed during the course, (e.g. domestic abuse, chronic illness) design a case study based on the following headings:

- **Externalising the problem**
- **Re-authoring**
- **Re-membering**
- **Outsider – witness practice**

Discuss the technique of developing the preferred story in family counselling related to this case.

A.4.3. Bereavement Family Counselling Training

A 4.3.1. Course Outline

SIYAHLANGANISA BEREAVEMENT FAMILY COUNSELLING COURSE

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8h30 - 8h35	Welcome & prayer	Welcome & prayer	Welcome & prayer	Welcome & prayer	Welcome & prayer
8h35 - 9h00	Registration Course expectations	Devotional	Devotional	Devotional	Devotional
9h00 - 9h30	Introduction of participants Information about Siyahlanganisa	*Ice-breaker* Family personalities Heroes & clowns	*Ice-breaker* Family relationships Thick & thin	*Ice-breaker* Family context Memories & treasures	*Ice-breaker* Family legacies Precepts and intentions
9h30 - 10h30	Content & purpose of the genogram *Presentation*	Psychological make-up of the family *Presentation*	Family life cycle *Presentation*	Family systems *Presentation*	Family ethics *Presentation*
10h30 - 11h00	TEA BREAK	TEA BREAK	TEA BREAK	TEA BREAK	TEA BREAK
11h00 - 12h00	Acquired skills in making a genogram Personal family history	Application to personal family genogram	Application to personal family genogram	Application to personal family genogram	Application to personal family genogram
12h00 - 13h00	Family counselling in chronic illness *Presentation*	Family counselling in bereavement *Presentation*	Family counselling in complicated grief *Presentation*	Family counselling in post traumatic stress disorder *Presentation*	Family counselling in grief complicated by poverty and unemployment *Presentation*
13h00 -13h30	LUNCH BREAK	LUNCH BREAK	LUNCH BREAK	LUNCH BREAK	LUNCH BREAK
13h30 - 14h30	Family counselling in chronic illness *Case study*	Family counselling in bereavement *Case study*	Family counselling in complicated grief *Case study*	Family counselling in PTSD *Case study*	Family counselling in grief complicated by poverty and unemployment *Case study*
14h30- 15h45	Family counselling in chronic illness *Discussion or role play*	Family counselling in bereavement *Discussion or role play*	Family counselling in complicated grief *Discussion or role play*	Family counselling in PTSD *Discussion or role play*	Family counselling in grief complicated by poverty and unemployment *Discussion or role play*
15h45 -16h00	Evaluation & prayer	Evaluation & prayer	Evaluation & prayer	Evaluation & prayer	Evaluation & prayer

310

A.5.   Siyahlanganisa Centre

Ukuphila Komndeni (Family Health) Programme

Pre & Post Questionnaire

Personal Details:

Name:	
Surname:	
Phone:	
Cell:	
E-mail:	
Church:	

A.5.1   COURSE EXPECTATION FORM

Please answer the following questions:

1. **What has motivated you to attend this course?**

2. **What do you hope to learn from this course?**

3. **How would you want to apply what you're hoping to learn?**

4. **Which mental health problems are prevalent in your home church and community?**

5. **Who attends to people and families that have these problems?**

6. **If people with these problems would ask for help,**
    - **who would be the person to help them in the church?**
    - **Who would they be referred to outside of the church?**

7. **Do you think it is important that people seek counselling as a family? Give reasons**

8. **Can you think of situations where it would be better not to have the whole family coming in for counselling**

9. **What kind of problems are most suited to deal with as a family?**

10. **After completing this course would you offer your counselling skills to the church? Give reasons.**

A.5.2. Siyahlanganisa Centre

Ukuphila Komndeni (Family Health) Programme

Personal details

Name:	
Surname:	
Phone:	
Cell:	
E-mail:	
Church:	

EVALUATION FORM

Please answer the following questions:

1. **What has motivated you to attend this course?**

2. **What have you learned from this course for your own personal and family life?**

3. **What have you learned from this course for your work with families in the church/community?**

4. **How would you want to apply what you've learned?**

5. **Which mental health problems are prevalent in your church and community?**

6. **Who attends to people and families that have these problems?**

7. **If people with these problems would ask for help,**
   - **Who would be the person to help them in the church?**
   - **Who would they be referred to outside of the church?**

8. **Do you think it is important that people seek counselling as a family? Give reasons**

9. **Can you think of situations where it would be better not to have the whole family coming in for counselling?**

10. **What kinds of problems are most suited to deal with as a family?**

11. **After completing this course would you offer your counselling services to the church? Give reasons**

A.5.3. Bereavement Counselling Course Evaluation Form

Name: _____   **Year**_____

Evaluation: On Applicability

On a scale of 1-5 (1 being the lowest and 5 being the highest) please rate the following in regard to their applicability in your ministry:

Chronic Illness	1	2	3	4	5
Bereavement Counselling	1	2	3	4	5
Complicated Grief	1	2	3	4	5
Poverty	1	2	3	4	5
Genogram	1	2	3	4	5
Counselling families	1	2	3	4	5

Evaluation of the training course in general:

List 3 key ways the course has made an impact on you:
1.
2.
3.
Were there any areas that you would have liked to be addressed that were not? Yes/No. If Yes please explain briefly:

What areas that have been addressed would you like to learn more about:

Mention one (or more) spiritual highlight(s):

Are you leaving with fresh ideas of how to take the next steps in addressing HIV/AIDS in your ministry? Explain.

Are there challenges for the future in which you would like more support?
 If so, explain.

Other Comments:
Are you planning to attend the second family counselling course on issues of mental health in the community?

On a scale of 1-5 (1 being the poorest and 5 being excellent) rate the following:

Quality of the teaching	1	2	3	4	5
Quality of the venue	1	2	3	4	5
Quality of materials	1	2	3	4	5
Usefulness of the materials	1	2	3	4	5
Teaching methodology	1	2	3	4	5
Relevance of the course	1	2	3	4	5
Approachability of the lecturer	1	2	3	4	5

NB: Questions five to ten from the course evaluation on page 288 were put to pilot group three, as part of the course content.