

**COUNSELLORS PERCEPTIONS OF APPLYING COGNITIVE
BEHAVIOURAL COUNSELLING APPROACHES TO
INTERVENTION FOR HIV SEXUAL RISK REDUCTION**

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ABSTRACT

There are two dominant approaches to counselling for sexual risk reduction in South Africa. The TASO model which is based on client centred principles, informs much of VCT counsellors' training. More recently, the (ARRM) AIDS Risk Reduction Model which includes a cognitive behavioural component to counselling for sexual risk reduction has been introduced.

A sample of VCT counsellors who have been trained using the ARRM were interviewed to develop an understanding of their experiences of using this approach. These participants provide a VCT service to clients in the midlands of the province of KwaZulu-Natal.

A central finding was that although counsellors experienced the cognitive behavioural approach as having good potential for effecting sexual behaviour change, numerous barriers were identified to applying the approach within the South African context. Counsellors were also critical of the TASO model as a model for counselling for sexual risk reduction.

Elements of the cognitive behavioural approach they experienced as useful included its potential for changing cognitions (misconceptions and myths in communities), the collaborative nature of the approach, negotiating strategies for risk reduction, use of a problem solving approach, follow-up and monitoring of behaviour. Barriers identified included contextual constraints such as poverty, gender power differentials and cultural practices. Also identified as a barrier was the dominance of the biomedical approach within the health care system. Despite identifying barriers to the application of this approach, counsellors remained optimistic that cognitive behavioural approaches could be adapted to the life context of their clients and that this could be facilitated through further training and mentoring.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
ARRM	AIDS Risk Reduction Model
CB	Cognitive Behavioural
CBVCT	Community – based HIV voluntary counselling and testing
HBM	Health Beliefs Model
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IDU	Injection Drug User
MTCT	Mother to Child Transmission
PHC	Primary Health Care
PMTCT	Prevention of mother-to-child HIV transmission
TASO	The AIDS Support Organisation
UNAID	United Nations Programme for HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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DECLARATION

I, Kamilla V. Rawatlal, declare that the contents of this study represents the author's own research and writing, and that no source material has been falsely used or unacknowledged.



Kamilla V. Rawatlal

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CHAPTER ONE

1. INTRODUCTION

Reviewing VCT counsellor training in the South African context revealed that historically a Client Centred Model has been adopted. More recently, however, training counsellors for sexual risk reduction based on the AIDS Risk Reduction Model has introduced a Cognitive Risk Reduction component to VCT counsellors' training. This research attempted to question the applicability of recent Cognitive Behavioural Approaches to intervention for HIV sexual risk reduction by exploring counsellors' experiences and perceptions of using this model.

Using a qualitative, interpretivist approach, using Case Study methodology, this study expands our knowledge in the field of VCT and sexual risk reduction by departing from dominant quantitative research approaches that have informed much of VCT research. Solomon, Van Rooyen, Griesel, Gray, Stein and Nott (2004) contend that qualitative research is more urgently needed to analyse the motives underlying sexual behaviour, document the practice of VCT and establish the preconditions for its efficacy as a preventative and supportive tool. They further argue that, at present, quantitative data dominates the published literature.

This study was considered important as it sought to explore and understand the field of HIV and AIDS Counselling through appreciating the subjective experiences of social actors and by unearthing data that can not be easily accessed by quantitative measures. As Rachier, Gikundi, Balmer, Robson, Hunt and Cohen (2004) contend "Counsellors need to

be consulted if the optimum services are to be provided, but they are rarely consulted for their professional opinion” (p.1).

1.1 The Impact of the Epidemic Globally and Nationally

Globally it was estimated that in 2004, there were 39.4 million people worldwide living with HIV. Of these, 17.6 million were women whilst 2.2 million were children. Almost 12% (4.9 million) of these became newly infected in 2004. AIDS deaths are estimated at 3.1 million per year (UNAIDS, 2004). HIV and AIDS remain two of humankind’s biggest challenges and threaten to reverse the gains made in advancing development and political stability, particularly in the African continent, where an estimated 25.4 million individuals are infected. In South Africa, a total number of 5.6 million individuals had acquired HIV infection by the end of 2003 (Department of Health, 2004).

The National Department of Health’s, National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa (2004) based on blood samples taken from pregnant women attending antenatal clinics revealed that nearly forty percent of women aged between 25 and 29 years in South Africa are HIV positive. Women in the early twenties and early thirties show lower rates at around 30% prevalence. Older women and teenagers have prevalence rates below 20%. The findings of the 2004 survey indicate that HIV prevalence among pregnant women is 29.5% compared to the 27.9% observed in 2003. The estimations of the survey revealed females infected range from 3.07 million to 3.6 million. The estimated number of males infected range from 2.6 million to 3.07 million.

The report highlights that “we do need to continue emphasising prevention and must therefore continue to promote safer sex behaviour such as abstinence, being faithful and using condoms (ABC messages), otherwise we may be faced with an HIV epidemic that is still to peak in the lower prevalence provinces” (Department of Health, 2004, p.17). Van Dyk (2005) contends that because there is no cure for HIV infection or AIDS, our best defence against infection is prevention.

The human immunodeficiency virus has four main means of transmission : unprotected sexual intercourse, the use of infected syringes, contaminated blood transfusion, and vertical transmission from mother to unborn child. However the principal means of transmission in South Africa is unprotected intercourse. The modification of sexual behaviour thus remains the most important method of halting the spread of infection. Strategies for the prevention of HIV infection range from the dissemination of information to the provision of counselling as part of HIV testing.

Voluntary Counselling and Testing (VCT) is regarded as a priority for preventing the spread of HIV and to provide care, support and treatment to people already living with HIV (Human Sciences Research Council, 2005). The South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey (2005) also found that there has been a notable increase in the uptake of HIV testing over time. Over two-thirds of those respondents who have been tested were tested in the past two years (Human Sciences Research Council, 2005).

1.2 Defining Voluntary HIV Counselling and Testing (VCT)

Voluntary Counselling and Testing is a central component of the South African government's strategy to prevent the spread of HIV and to provide care and support to those living with AIDS (Birdsall, Hajjiannis, Nkosi and Parker, 2004).

The first definition of VCT, and perhaps the most important in terms of the plan to reduce the impact of HIV/AIDS, is a definition that describes the roles and function of VCT as primarily preventative. This preventative function is described in two ways. First, VCT is seen to be preventative in terms of inhibiting the spread of HIV/AIDS between people. In this construction of VCT, the primary and direct benefit of promoting HIV counselling and testing is its ability to inhibit the spread of new infections.

Van Dyk (2005) argues that it is extremely important for the counsellor to counsel HIV negative clients in order to reduce the chances of future infection. She argues that risk reduction and safer sex practices must be emphasised. "Some people who practise high - risk behaviour and test negative believe that they are "immune" to HIV and that precautions are therefore unnecessary. This dangerous assumption must be rectified" (Van Dyk, 2005, p. 208). The second preventative function of VCT is the prevention of further illness in people who are diagnosed as HIV positive.

HIV counselling has been defined as "a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal

decisions related to HIV/AIDS. The counselling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour (UNAIDS, 2000). The objectives of HIV counselling are the prevention of HIV transmission and the emotional support of those who wish to consider HIV testing, both to help them make a decision about whether or not to be tested , and to provide support and facilitated decision making following testing.

The VCT process consists of pre-test, post-test and follow-up counselling. HIV counselling can be adapted to the needs of the clients and can be for individuals, couples, families and children. It can also be adapted to the needs and capacities of the settings in which it is delivered. The content and approach may also vary considerably for men and women and with various groups, such as counselling for young people, injecting drug users and sex workers (UNAIDS, 2004).

1.3 VCT as an HIV Prevention Strategy (International and Local Literature)

In most developed countries, the drive towards voluntary counselling and testing (VCT) is now very advanced. Counselling has long been recognised as having an important role to play in both the prevention of HIV infection and the provision of care and emotional support for those infected and affected by the virus (Brouard,1998; Tallis,1994). It is the biggest and most costly HIV/AIDS preventive effort ever mounted in the USA (Weinhardt, Corey, Johnson, Bickham, 1999).

The Voluntary HIV Counselling and Testing Efficacy Study (2000) was designed to measure the efficacy of VCT in developing countries and resource poor settings where access to antiretrovirals and other expensive medications is difficult or impossible. The results of the Voluntary HIV – 1 Counselling and Testing Efficacy Study support the efficacy and cost-effectiveness of HIV voluntary counselling and testing (VCT) for reducing risk behaviours in three developing countries. The study was conducted at three sites : Nairobi, Kenya; Dar es Salaam, Tanzania; and Port of Spain, Trinidad. These sites were chosen to represent a variety of epidemiological and cultural contexts in developing countries in which VCT counselling and testing would occur. All sites were urban. Overall 4293 participants were enrolled. Participants enrolled as couples or as individuals. Data were collected from 1995 to 1998. Participants were consented, completed a base line interview and were then randomly assigned to receive either HIV counselling and testing or health information.

The study found that VCT was estimated to avert 1104 HIV infections in Kenya and 895 in Tanzania during the subsequent year. The study revealed that VCT is highly cost-effective in urban east African settings, but slightly less so than interventions such as improvement of sexually transmitted disease services and universal provision of nevirapine to pregnant women in high prevalence settings. The study reinforces the benefits and cost effectiveness of HIV VCT as part of a comprehensive package of prevention strategies for the developing world.

Weinhardt, Carey, Johnson and Bickham (1985-1997) published a meta-analysis of the effects of HIV counselling and testing in 1999. Most of the studies had been conducted in the USA, although six were done in Africa and two in Europe. The indicators they used to determine effects were unprotected sex, condom use, number of sexual partners, and STD and HIV incidence. The results revealed that discordant couples and people informed of being HIV positive showed reductions in unprotected intercourse and increased condom use. The same group showed decreased incidence of STDs and HIV. No risk reduction in unprotected intercourse was found amongst HIV – negative individuals or amongst individuals who did not know their serostatus. However tested individuals, whether HIV-positive or HIV – negative, reduced their numbers of sexual partners in comparison to people who did not know their status.

Weinhardt et al., (1999) drew five conclusions from their analysis. They contended that there was not much evidence for VCT being an effective primary prevention strategy to prevent HIV-negative tested individuals from being infected. However, given the lack of attention paid to the details of counselling and presumed psychological factors that may interact with VCT to affect behaviour change in the review, further assessment was deemed necessary. The role of the counsellor in prevention of HIV, however cannot be undermined. As, Rachier, Gukundi, Balmer, Robson, Hunt and Cohen (2004) state, "Initially, the aim of HIV testing was to give the client a sero-status test result and promote behaviour change. This was done largely through information and education procedures. However, the critical importance of counselling as a means of behaviour change has been acknowledged" (p. 176).

Further to this a study reported by Kamb et al; (1998) indicated that what they call “enhanced counselling” (2 or 4 interactive sessions) increased condom use and decreased STD infections among HIV-negative heterosexual individuals. Further research was deemed necessary to examine the effectiveness of different theoretical models and counselling approaches, including different contexts, modes of delivery and levels of intensity.

Phillips and Coates (1995) suggest that VCT should be viewed as one part of an overall HIV prevention strategy that requires interventions at multiple levels, these include social influence at national, community, interpersonal and individual (Phillips & Coates, 1995). Further, because sexual behaviour is a product of interpersonal interaction and is shaped by social influences, it has been suggested that couple or group counselling may prove more effective as well as more economical than standard one-to-one counselling (Ickovics, cited in Richter et al.,1999). There are indications for the efficacy of multiple session group interventions to change high-risk behaviour (Balmer,1994; Kelly & St Lawrence, cited in Richter et al., 1999). For example, focus groups over several sessions were experienced as very helpful by HIV-positive women in Zimbabwe (Krabbendam, cited in Richter et al., 1999).

1.4 VCT Counselling in South Africa

Richter, Van Rooyen, Durrheim, Griesel, Solomon (1999), in their ‘evaluation of HIV/AIDS counselling’ in South Africa found in general that there was a high degree of

uniformity in counselling practices. While they had anticipated that novel, innovative and creative approaches may have developed in response to the specifics of local contextual conditions and cultural differences this expectation was not met. The uniformity in counselling practices was attributed to possible training effects, the dominance of a biomedical orientation in both training and counselling settings and the urgency and goal directedness of the single counselling encounter.

1.4.1 Issues Related To Training and Settings

With regards to training Richter et al., (1999) found that the general trend in South African training programmes was to divide course material into two components, generic counselling skills and HIV/AIDS knowledge. It was suggested that this separated training approach may have made it difficult for counsellors to integrate counselling skills and HIV/AIDS knowledge in practice. Further, Silverman (1997) contends that a powerful determinant of a counselling service is the nature of the site in which the service is situated. Much of HIV/AIDS counselling in South Africa takes place in testing sites or health care settings which are dominated by a biomedical orientation. Richter et al., (1999) suggest that the dominance of the biomedical orientation within the health care system may make it difficult for counsellors to include the psychosocial aspects of HIV/AIDS in service rendition, thus inhibiting the potential of counselling. The biomedical approach is also regarded as limiting interaction to a mechanistic view where the emphasis is on the transfer of information as opposed to the establishment of mutual understanding through dialogues. Communication within this approach is conceptualised as a one way flow (from health care worker to the patient) in which information is used as

an instrument to bring about change (compliance). The dominance of the biomedical approach is considered problematic when one considers that in South Africa a range of social and psychological processes are at the heart of the HIV/AIDS epidemic. Social factors include economic factors, lack of education, working conditions, gender inequality. Psychological processes include low levels of self-efficacy, knowledge and beliefs.

Counselling then is only used to serve the needs of the health system or site rather than the needs of the populations. Further, Richter et al., (1999) suggest that the very time limited nature of VCT also limits the counselling relationship. Most counsellors reported difficulty arranging follow-up sessions and clients failing to return for test results. The uncertainty regarding whether the client will be seen again may contribute to shaping the counsellor orientation in a more goal-orientated, urgent and directive direction.

Most VCT consists of only one or two sessions, and several studies have shown that single sessions of counselling have few if any effects on preventive behaviours (Richter et al.,1999). Apart from anything else, studies conducted in Africa and elsewhere have reported the difficulties of getting across in a single session an adequate understanding of HIV and its personal and social implications. Richter et al., (1999) suggest that VCT may need to consist of more extensive interventions than the one pre-and post session of counselling which has become “pretty standard” and that VCT should be part of a multi-pronged intervention that addresses the many powerful social, political, structural and economic factors that determine the prevalence and spread of the epidemic.

1.5 Motivation for focusing on the Cognitive Behavioural Model (ARRM)

In this chapter the following has been discussed; (a) the impact of the epidemic globally and nationally, (b) defining VCT, and (c) exploring VCT as an HIV prevention strategy. I also attempted to contextualise VCT counselling in the current context by exploring VCT counselling in South Africa. In this research an attempt to identify dominant theoretical models to counselling for sexual risk reduction is made. A review of the literature on VCT counselling training in South Africa revealed that historically a Client Centred Model has been adopted. More recently, however, training counsellors for sexual risk reduction based on the AIDS Risk Reduction Model has introduced a cognitive risk component to VCT counsellors' training. Given that this is a recent development, the aim of this study was to develop an understanding of the applicability of this recent Cognitive Behavioural Approach to intervention for HIV sexual risk reduction in the South African context.

CHAPTER TWO : LITERATURE REVIEW

In this literature review I begin with a review of models of behaviour change that have informed HIV/AIDS prevention efforts. The Health Belief Model, the AIDS Risk Reduction Model, the Information - Behavioural Model, Social Learning Theory and the Theory of Reasoned Action are all believed to be essential for individuals to enact and sustain behaviour and are based on cognitive models of behaviour change. These theories have been applied in the United States and more recently the ARRM based on cognitive models of behaviour change have been applied in South Africa. The Client Centred Model, (TASO) which has historically been used to train VCT counsellors in the South African context is also discussed. Recent developments on the applicability of the Psychoanalytic Approach are also introduced to provide an understanding of alternate perspectives to counselling for sexual risk reduction counselling. Lastly, limitations of Individual Based Approaches to Sexual Risk Reduction are explored.

2.1 Cognitive Models of Behaviour Change

2.1.1. *The Health Behavioural Model*

The Health belief model is based on the premise that perceptions of personal threats are a necessary precursor to taking preventative action (Kalichman,1998). It argues that an individual will engage in health behaviour, such as safer sex, if that individual perceives him/herself as vulnerable or susceptible to a health threat is perceived as having serious consequences, the protective action that is available is perceived to be effective and the benefits of that action are seen as outweighing the perceived costs of the action (Bloor,1995). Taken together, these belief elements about threats of potential risk and

outcome expectancies produce a psychological readiness for action. If the degree of readiness is above a certain threshold, and the environment conditions allow the action, the behaviour is likely to occur and change to be initiated (Kirscht & Joseph, 1989). The key variables of the HBM are as follows: a) Perceived Threat : Consists of two parts: perceived susceptibility and perceived severity of health condition. (1) Perceived Susceptibility : one's subjective perception of the risk of contracting a health condition (2) Perceived Severity : Feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical consequences and possible social consequences.

(b) Perceived Benefits : The believed effectiveness of strategies designed to reduce the threat of illness.

(c) Perceived Barriers : The potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands.

(d) Self Efficacy : The belief in being able to successfully execute the behaviour required to produce the desired outcome.

Unfortunately, the relationship between HBM elements and safer sexual behaviour is inconsistent (Fisher and Fisher,1992). Several studies have shown that perceived susceptibility to HIV, perceived costs and benefits associated with prevention and cue presence can be entirely unrelated to safer sex behaviour.

2.1.2 The Information – Motivation Behaviour Model

This model Proposed by Fisher and Fisher (1992) suggests that HIV risk reduction is determined by largely by 2 independent factors : (1) information about HIV transmission

and (2) motivation to reduce infection. However these factors will only result in behaviour change if the individual has the “behavioural skills” to perform preventative acts. The motivation component of the IMB model recognises the importance of cognitive factors in so far as motivation is determined by “attitude”, which is in turn a product of beliefs about consequences and the evaluation of consequences (Ajzen & Fishbein, 1980). Unfortunately few suggestions are made as to how these specific subcomponents of the model might be modified in a therapeutic situation.

2.1.3 Social learning theory

Social learning (cognitive) theory is based on the premise that behaviours, environmental influences, and beliefs are highly interactive and dependent (Kalichman, 1998). It explains human functioning in terms of “triadic reciprocal causation” (Bandura, 1994, Kalichman; 1998). In this causal model, (1) personal determinants in the form of cognitive, affective and biological factors, (2) behaviour, and (3) environmental influences, are said to all operate as interacting determinants of each other (Bandura, 1994). Central to this theory is the notion of self efficacy, which refers to the perception that one is, or is not, capable of performing a behaviour (Valdiserri, 1989). Persons may be engaging in high risk behaviour due to their doubt as to whether they can protect themselves from HIV infection. For example, they may have relatively low self efficacy because the self protective behaviours and the situations involved may be unfamiliar to them, or they may undermine their self efficacy (Valdiserri, 1989). An implication of this is the recognition that providing people with the skills for behaviour change will improve their self

efficacy, which in turn, will increase their persistence in maintaining the behaviour change (Valdiserri, 1989).

2.1.4 Theory of Reasoned Action

Research using the Theory of Reasoned Action (TRA) has explained and predicted a variety of human behaviours since 1967. Based on the premise that humans are rational and that the behaviours being explored are under volitional control, the theory provides a construct that links individual beliefs, attitudes, intentions, and behaviour (Fishbein, Middlestadt & Hitchcock, 1994). The theory variables and their definitions, as described by Fishbein et al. (1994):

Behaviour : A specific behaviour defined by a combination of four components : action, target, context, and time

Intention : The intent to perform a behaviour is the best predictor that a desired behaviour will actually occur. In order to measure it accurately and effectively, intent should be defined using the same components used to define behaviour : action, target, context, and time. Both attitude and norms, described below, influence one's intention to perform a behaviour.

Attitude : A person's positive or negative feelings toward performing the defined behaviour

Behavioural Beliefs : Behavioural beliefs are a combination of a person's beliefs regarding the outcomes of a defined behaviour and the person's evaluation of potential outcomes. These beliefs will differ from population to population.

Norms : A person's perception of other peoples opinions regarding the defined behaviour.

Normative Beliefs : Normative beliefs are a combination of a person's beliefs regarding other people's views of a behaviour and the person's willingness to conform to those views. As with behavioural beliefs, normative beliefs regarding other people's opinions and the evaluation of those opinions will vary from population to population.

The TRA provides a framework for linking each of the above variables together. Essentially, the behavioural and normative beliefs referred to as cognitive structures – influence individual attitudes and subjective norms, respectively. In turn, attitudes and norms shape a person's intention to perform a behaviour. Overall, the TRA model supports a linear process in which changes in an individual's behavioural and normative beliefs will ultimately affect the individual's actual behaviour.

Some of the limitations of the TRA include the inability of the theory, due to its individualistic approach, to consider the role of environmental and structural issues and the linearity of the theory components (Kippax and Crawford, 1993). Individuals may first change their behaviours and then their beliefs/attitudes about it.

2.2 MODELS OF VCT IN SOUTH AFRICA

Introduction

Reviewing counsellors trained in VCT in the South African context revealed that there are two key orientations used in the training of counsellors : open ended client centred and more recently cognitive directive. The AIDS Support Organisation (TASO) model adopts the former orientation and uses Egans's (1986) 3 Stage Self Help Problem Management Method. The AIDS Risk Reduction Model (ARRM) which has been recently introduced, adopts a more cognitive directive approach. These three models are expanded on in greater detail.

2.2.1 The AIDS Support Organisation (TASO) Model

This model was developed in Uganda in 1987 and is based on client centred principles as well as including behavioural skills acquisition as part of the training. There are a number of private AIDS organisations in South Africa that provide training and education of counsellors in this model. Examples include ATTIC, Lifeline, ACT (AIDS Consultancy & Training). According to the TASO model, counselling follows four stages illustrated on the following page, in Figure 1.

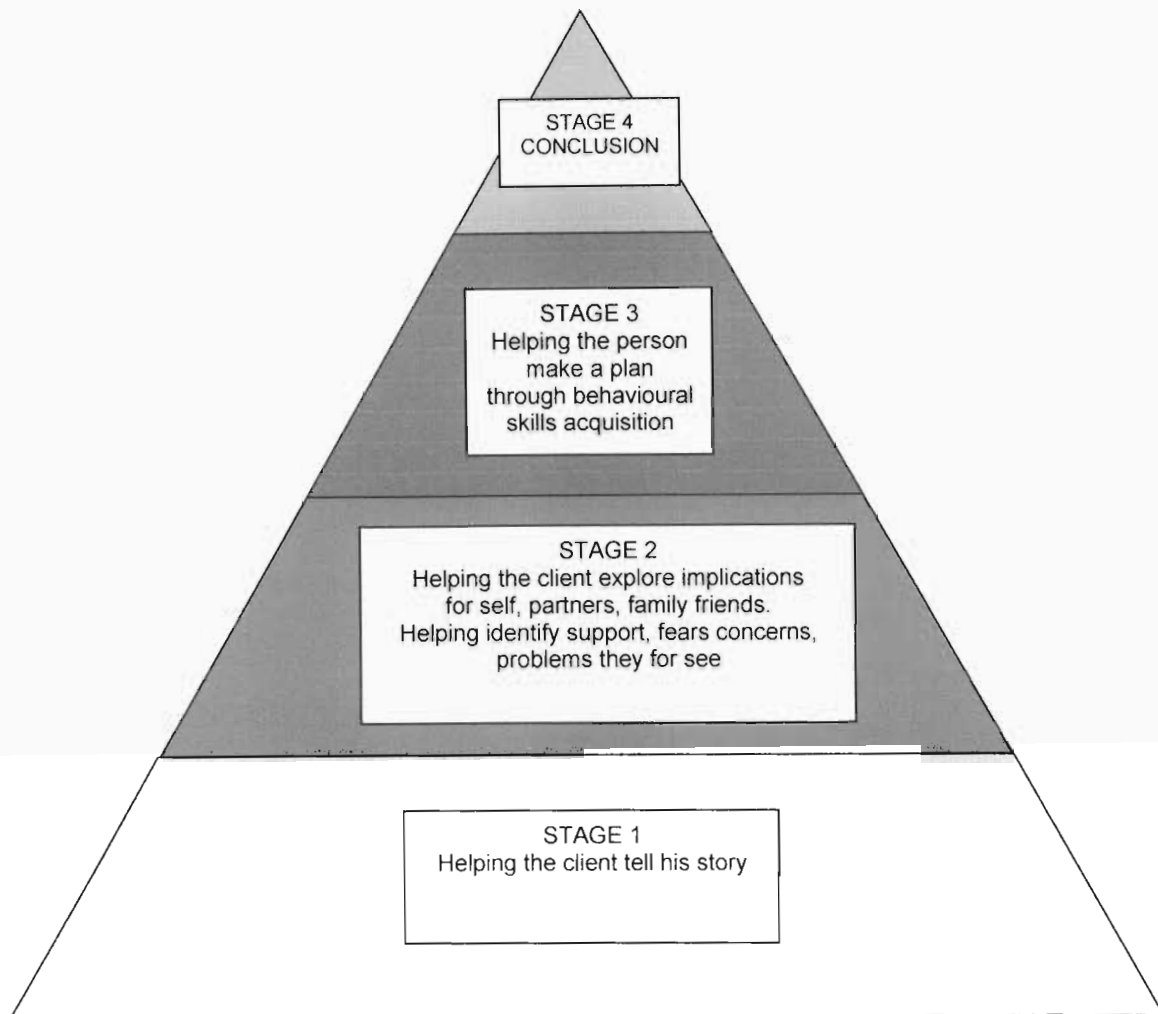


Figure 1 : Stages in the TASO Model

The TASO model adopts Egan's (1986) client centred 3 stage Problem Management Process, which promotes the idea that people are responsible for and capable of making their own decisions. The client directs the counselling and chooses what he feels comfortable to work with. The client centred approach emphasizes the centrality of the counsellor - counsellee relationship and aims to develop counsellors who respect the position of those they counsel without imposing their own values. Growth is achieved by believing in the client's potential to solve his own problems and therefore working

towards a future independence where he will no longer require facilitation by a counsellor. In practice this means that the counsellor engages in the following process : summarising or verbalising the feelings of the client, problem identification, encouraging the person to give potential solutions to the problem, adds alternatives to the possible solutions using knowledge and creativity, gets the person to weigh up the different potential solutions by working through the advantages and disadvantages of each possible solution.

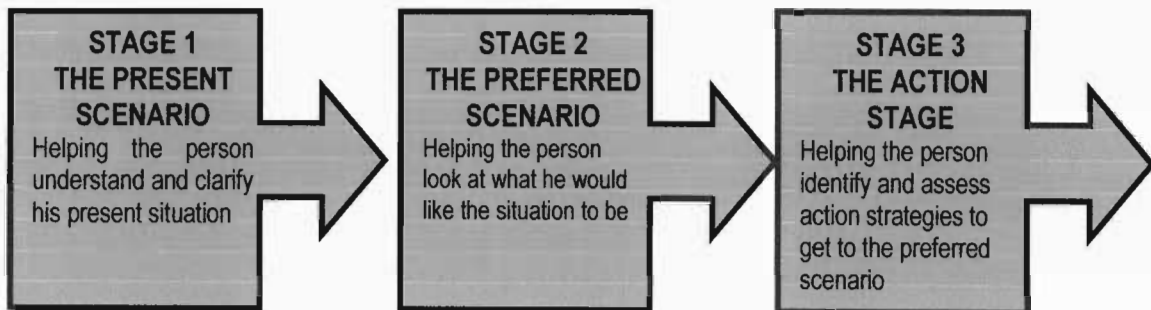


Figure 2. Egan's (1986) 3 Stage Self Help Problem Management Method

2.2.2 AIDS Risk Reduction Model (ARRM) : Cognitive Approach

More recently in South Africa the ARRM model has been introduced to training VCT counsellors for sexual risk reduction. While still adopting client centred elements this model includes **a cognitive behavioural component** to counsellors training. It is influenced by the Health Belief Model, self efficacy theory and psychological theory and research on interpersonal processes and attitude change (Fisher and Fisher, 2000).

The AIDS Risk Reduction Model (ARRM) assumes that behaviour change is a process and that different factors affect movement through different stages of the process. The ARRM views progress through the stages of change as an important intervention outcome. According to stage theorists, viewing actual behavioural change as the only critical intervention outcome may lead to the omission of important variables (eg. perceptions of susceptibility to HIV, perceptions of HIV risk behaviour as being problematic) that may affect the process of change, and consequently behavioural outcomes. The model provides insights into the process of HIV risk reduction behaviour change and how to move people through the process of change, as well as being concerned with why people fail in the change process. This model requires the negotiating of a Risk Reduction Plan between the counsellor and the client. Steps include those listed in Figure 3.

1. Identifying priority risk reduction behaviour
2. Exploring behaviour(s) that the client will be most motivated about or capable of changing
3. Identifying a reasonable yet challenging incremental step towards changing the identified behaviour
4. Breaking down the risk reduction action into specific and concrete steps
5. Identifying supports or barriers to the risk reduction step
6. Problem solving issues concerning the plan
7. Role Playing the plan
8. Confirming with the client that the plan is reasonable and acceptable
9. Asking the client to be aware of strengths and weaknesses in the plan while trying it out
10. Recognising the challenges of behaviour change
11. Documenting the risk reduction plan with a copy to the counsellor

Figure 3. Steps in the Risk Reduction Plan

Skills and characteristics of effective counsellors using the ARRM include the following: a belief that HIV prevention counselling can make a difference in preventing and controlling HIV for the individual, the family, and the community, balancing well-selected open-ended questions with statements, summaries, and reflections that guide the session and maintain the focus on risk issues, remaining focused on risk issues and helps the client develop a realistic and relevant risk reduction plan, remembering to clarify important misconceptions, but avoids extended talk on issues not related to risk. (Adapted from CBVCT Intervention Training Course, Project Accept, Soweto, Johannesburg, August, 2004)

2.2.3 MOTIVATION FOR FOCUSING ON THE COGNITIVE BEHAVIOURAL MODEL TO COUNSELLING (ARRM)

Reviewing VCT counsellor training in the South African context revealed that the dominant approach has been client centred. Evaluation of the actual practice of VCT indicates, however, that although counsellors are trained in the client centred approach, they tend to adopt a more health advising approach. This was understood to be a product of the training and context in which VCT takes place. (Richter et al., 1999).

More recently, however, training counsellors for sexual risk reduction, based on the AIDS Risk Reduction Model (ARRM) has introduced a cognitive risk reduction component to VCT counsellor training. Given that this approach has been recently introduced in South Africa and there has been little evaluation of this model, this research focuses on exploring the counsellors' experiences and perceptions of this model in relation to its applicability for counselling for sexual risk reduction in the South African context.

2.3. LIMITATIONS OF INDIVIDUAL BASED APPROACHES TO SEXUAL RISK REDUCTION

2.3.1 Socio-Cultural Perspectives

The value of VCT, and of HIV/AIDS counselling more broadly, has been widely debated in both the lay media and the academic literature. Much of the literature advocating the use of counselling for HIV prevention is concerned with showing why it is that counselling, as an individualised, non-didactic problem solving exercise, is a more effective behavioural intervention than education alone. While these arguments are generally accepted, proponents and critics of VCT and counselling alike have nonetheless criticised what they perceive to be a Western, individualistic and bio-medical model of counselling. Questions have been raised in numerous discursive articles regarding counselling aims and objectives as well as counselling methodologies and practices (Lindegger and Wood, 1994; Richter et al., 1999).

Theories of behaviour upon which VCT and counselling interventions are based have been criticised for conceptualising the individual as the ultimate determinant of behaviour; thereby relegating contextual, environmental and social factors as confounding factors or barriers to, rather than primary determinants of, a rational decision-making process.

These individualistic, self empowerment models of counselling that has been criticised as limiting behaviour change through changing people, rather than also changing the contexts they are in. These critics argue that socio-economic and cultural contextual factors may be the most important determinants of behaviour, rather than simply being factors which moderate that behaviour (Standing, 1992).

Stein (1996) tackles the problem of the appropriateness of the HIV/AIDS counselling paradigm by analysing the history and origins of HIV/AIDS counselling from a Foucauldian perspective. Stein argues that individualistic models of VCT counselling assume there is hardly any aspect of HIV infection for which the individual is not accountable for. A viewpoint which is unsustainable in poorer communities where contexts and situations provide little self determination. Like many authors, she argues that self empowerment and self determination are only possible in a context of increased gains at the level of the individual's freedom of choice.

More conceptual or theoretical work is required to locate counselling convincingly as an effective and necessary behavioural solution to augment, rather than replace, the more fundamental structural social transformation required. Clearly, she argues, empowerment or helping the person to help themselves cannot be achieved unless the contextual constraints placed on individual decision making are removed. The question therefore remains whether counselling as it is presently understood is an appropriate form of support and prevention in African settings.

Cognitive theories have also been criticised for being largely centred around volitional control do no take into account individual, cultural (including gender and race), and related differentials of self efficacy and power in sexual interactions. According to Parker (2004), factors that disable volitional control over sexual activity and contribute to overall vulnerability to HIV infection include : differentials in language which limit effective communications, gender power differentials, peer influences, varying cultural practices, urbanisation and the changes in dynamics of marital relationships.

Cognitive approaches are also seen as being rooted in the early responses to the epidemic where behavioural interventions targeted relatively homogenous groups such as intravenous drug users, transport workers, gay men and sex workers. In these instances, target groups were relatively homogenous in terms of language, culture, context and risk practices and behaviour change interventions could be constructed with a clear vision of risks and strategies for risk reduction.

Parker (2004) thus contends that this notion of homogenous risk has been carried over into less homogenous groups that have more generalised exposure to risk – for example, youth, or women, or particular race or cultural groups. In heterogeneous populations, degrees of risk are seen to vary considerably.

He also argues that the concept of ‘behaviour change’ has also tended to be applied in quite a narrow way in terms of a person’s sexual lifespan. For example, the tendency to imply a change from one state of practice (inappropriate and risky behaviour) to another

state of practice (appropriate and low/no risk behaviour) is something that as a matter of course, will be consistently maintained is a weak assumption. Specifically, this assumption overlooks the complexity of sexual relationships and interactions that are influenced over a lifetime and that are influenced by diverse changing contexts – for example changing contexts and changing relative empowerment / disempowerment. Exposure to risk and individual capacity to moderate risk is thus seen as relative to these changing conditions.

Campbell and Cornish (2003) argue that first generation prevention efforts, sought to promote sexual behaviour change at the individual level, through providing people with knowledge about sexual health risks and training them in behavioural skills necessary for the performance of new behaviours. They contend that one study after another has highlighted that people often have unprotected sex with multiple partners despite having the necessary knowledge and skill to protect themselves. This is because health related behaviours are determined not only by conscious rational choice, but also by the extent to which community and societal contexts enable and support the performance of such behaviours.

Campbell and Cornish (2003) thus argue that our understandings of the mechanisms whereby community level processes impact on the likelihood of behaviour change remain in their infancy.

The micro-social aspects of HIV, they argue, have been well covered by psychologists, in a stream of studies linking sexual behaviour to properties of the individual (e.g. cognitive processes, perceived self efficacy and perceived social norms). At the macro-social level, economists, anthropologists and sociologists have highlighted how poverty, gender inequalities and global capitalism shape the contexts within which the pandemic flourishes. Whilst both micro-social and macro-social perspectives contribute essential frames in the kaleidoscope of factors implicated in the development and persistence of HIV, little attention has been paid to the way in which these factors play out at the local community level.

These issues form the focus of a recent South African study which took the form of a longitudinal process evaluation of community led HIV prevention programme for sex workers in the Summertown gold mining region near Johannesburg (Campbell, 2003). This study sought to address the challenges outlined above through investigation of the way in which structural inequalities played out at the local community level in ways that undermined the possibility of behaviour change.

Baseline research conducted at the project's inception (Campbell, 2000) suggested that despite high levels of knowledge about the dangers of HIV, sex workers typically engaged in high-risk sex. The construction of gender in the context of poverty, unemployment and violence played an important role in undermining the likelihood of condom use. Mineworker clients, driven by macho notions of masculinity associated with high levels of risk taking behaviour and multiple sex partners, were reluctant to use

condoms (Campbell, 1997). Women lacked both the psychological and economic power to insist. At the economic level, women could not afford to offend paying customers. Furthermore, the intensity of their competitive working conditions led to an atmosphere of conflict and jealousy amongst sex workers. Women also lacked the psychological power to assert themselves both as women in a male dominated context and as members of a highly stigmatised workforce, with little self respect or respect from others.

In a context where a permanent relationship with an employed man was the most effective economic survival strategy, almost every sex worker cherished the secret hope that a customer would fall in love with her and set up home with her. This made women particularly vulnerable to unscrupulous men, who trapped them into having unpaid and unprotected sex with insincere promises of love.

While some women were seen as receptive to peer educators health warnings, there was also a core of women, described by peer educators as "stubborn", who responded with fatalism or denial. They either refused to believe that they were vulnerable or insisted there was nothing they could do about it. Having little success in countering many problems in their lives, HIV/AIDS was simply one more problem about which they said they could do nothing.

In the case study by Campbell, (1999) she also highlights that sex workers attempts to use condoms in commercial encounters were further undermined by the continued unwillingness of many mineworker clients to co-operate. Within the mining industry

health and health promotion were seen as falling under jurisdiction of biomedical doctors. Given the predominance of the biomedical model in medical training and practice, many doctors, according to Campbell (1998) tend to be unfamiliar with the social understandings of disease transmission and prevention. Within this context, they dismissed peer education as 'vague and social science' and preferred to throw their energies into biomedical STI-control programmes.

This study thus highlights that much has to be learned about the factors shaping the likelihood that powerful stakeholders will collaborate in partnerships with local communities in addressing social problems such as HIV transmission. Much also remains to be learned about how to motivate such collaboration, in contexts where the problems affect members of marginalised communities who have little political or economic power of influence over more powerful stakeholders.

The sex worker case study outlined above sought to conceptualise sexual behaviour change as a community level goal, moving beyond traditional social psychology models which recommend changing individual cognitions. However, Campbell (2003) asserts that much work remains to be done in developing social psychological frameworks capable of tracing the processes and mechanisms whereby such social relations are translated from the macro-social to the community level of analysis, influencing local relationships in ways that undermine the likelihood of behaviour change.

A growing number of researchers are recognizing the gendered nature of risk influences for infection as well as the barriers to behaviour change. The work of Pleck (1993) on the relationship of masculine ideology and the sexual behaviour of white, black and Latino young men demonstrates how gender roles are of major importance in understanding sexuality and HIV risk behaviours. Pleck's analysis included a representative sample of 1,717 Black, Latino and non-Latino white adolescent boys ages 15-19. Pleck (1993) reported that even when controlling for socioeconomic status and personal background characteristics, boys who hold traditional attitudes toward masculinity indicate having more sexual partners in the last year, a less intimate relationship at last intercourse with the current partner, a greater belief that relationships between women and men are adversarial, more negative attitudes toward condom use, less current use of condoms, less belief in male responsibility to prevent pregnancy and a greater belief that pregnancy validates masculinity. These researchers conclude that traditional masculinity ideology is associated with characteristics that limit the quality of adolescent males' close heterosexual relationships, and increase risk of unintended pregnancy and sexually transmitted diseases among their female partners.

Amaro and Gornemann's (1992) study of women-only focus groups, found that the issue of power and gender roles emerged as a central barrier to risk reduction. Women talked about this in many ways, sometimes they referred directly to "machismo" and other times they noted men's stubbornness and unwillingness to use condoms, and expressed feelings of powerlessness, low self esteem, isolation, lack of voice and inability to affect risk reduction decisions or behaviours with partners. In contrast, in groups comprised of a

mixture of women and men, these issues were not discussed as frequently as in women-only groups-perhaps suggesting that issues of gender roles and power differentials in relationships are generally difficult for women to discuss openly with men.

Both authors argue that the tasks of safer sex negotiation for women requires them to act in conflict with women's traditional socialisation as unequals. Prevention approaches must be based on an understanding of what this task requires of women, and be designed to help women understand the social context of these actions and provide them with adequate support to carry out behaviours that would allow them to consider their social status.

Miller, (1986) argues that traditional theories of development are based on the notion that a feature of healthy development is disconnecting from relationships and that relationships from this perspective are viewed as a means to individual achievement. Miller (1986) proposed a connection - based theory of women's development, the Self - In-Relation Theory, which suggests that the "relational self" is the core of self structure in women and the basis for growth and development.

Amaro (1992) argues that a new model of HIV sexual risk that recognizes "connection" as a central feature in women's lives suggests that in order to better understand risk behaviour and risk reduction factors such as 1) centrality of connection to others as a core aspect of self, 2) degree to which conflict in relationships (especially conflict related to safer sex negotiation) and fear of disconnection is threatening to a women, 3) degree of

mutuality in the relationship with the male partner, 4) skills and comfort in dealing with conflict, 5) the degree to which pregnancy and childbearing are perceived to be avenues for connecting with male partners.

Amaro (1992) thus argues that current psychological theories regarding sexual risk behaviours have served an important purpose in helping us to understand some factors associated with HIV risk. However, these models are limited because they have neglected to consider the contextual factors that impinge on HIV sexual risk behaviour, especially those factors related to gender relations. He concludes that researchers studying HIV sexual risk behaviours would benefit from a close collaboration with researchers in the field of gender relations, the psychology of women and ethnic studies in order to further explore and empirically study how gender roles among both men and women of different ethnic and cultural groups affect sexual risk behaviours and risk reduction.

2.4 The Psychoanalytic Perspective

Kelly (2001) argues that the psychoanalytic model for interpreting human motivation and action offers an alternative to the largely rationalistic and behaviourist models which are most often used to understand behaviour and behaviour change in relation to HIV/AIDS, and to develop interventions aimed at changing behaviour.

In many contexts the psychoanalytic model works in the social domain because the issues at stake are broadly speaking aligned around the concept of in-groups and out-groups, which easily translates into the language of self other relations.

He suggests that it takes an understanding of the rule-defined nature of institutions, to understand how behaviour change can be sustained. This extends the understanding of behaviour change beyond the rationalistic and intentional domains. It also takes one into an understanding of the role of environments in creating contexts for change. The point that is thus argued is that one should take stock of this environment, in and of itself, to understand the location of the acting subjects within it.

Kelly (2001) points out that one can achieve any manner of single acts by acts of simple choice, but systems of behaviour, and the maintenance of behaviour change is hard won. He maintains that we need first to understand how institutions maintain their coherence, how institutional power works, rather than to begin with the psychology of people acting within institutions.

He asserts that behavioural models of sexual behaviour change are astonishingly lacking in the psychology of emotional life. There is almost no place in any of the models for understanding the "mad and bad" aspects of experience, fantasy life, or the instincts. But turning to the *contexts* of experience, there has also been little understanding of the place of our society in understanding behaviour (Airhinnbuwa & Obregon, 2000).

The psychoanalytic model makes reference to how multi-faceted and contingent sexual activity is in its manifestations. Questions as to the manifestations of sexual desire have led psychoanalysts from discussions of the role of the instincts in human activity to

consideration of the place of language and signification. Kelly (2001) argues that sex can show itself in the most unlikely of places and sexual interest could conceivably drive almost any human experience. He contends that analyses have connected sex with power, with affectional needs, with needs for affirmation, and much else besides. He states that "the study of sexual biographies reveals a large range of reasons for people wanting to have sex. This poses a challenge, for if sexual activity is not a unitary phenomenon and not a directly intentional phenomenon it is hard to imagine how we might develop models for behaviour change in the sexual domain. The reason why a person would have multiple sex partners without taking HIV risk reduction measures are arguably different in each case. "We cannot analyse the reasons for not using condoms by a simple account based on the presence or absence of knowledge, attitudes and beliefs, perception of vulnerability or any other rationalistic explanation" (Kelly, 2001, p. 6).

Kelly (2001) argues that there has been relatively little work done at the level of explanation and intervention and there is relatively poor understanding of the psychological and social dynamics relating to risk exposure and intervention. Furthermore he contends that, the knowledge, attitudes and practices of individuals have been the primary concern of most social researchers, whilst the contextual determinants of behaviour in the areas of prevention and care have been given scant attention. However, in studying contexts one inevitably comes across individual differences, and it is this that has become the focus of psychoanalytic writings. He argues that there needs to be an appreciation of the emotional and symbolic universes which span the space between people and their environments.

Joffe's (1999) work on "risk and the other" is seen as an important contribution to the study of risk and HIV/AIDS and draws extensively on psychoanalytic perspectives. Joffe (1999) extends an understanding of splitting to appreciate how anxiety about susceptibility to risk is projected onto outgroups. Joffe's concern is how to fill in the gap between knowledge and practice exploring the emotional and symbolic aspects which impact on the estimation of risk.

It is no doubt adaptive not to live in constant awareness of the risks which assail us and Joffe looks at how we achieve this. Briefly, she believes that we project the possibility of vulnerability onto the other. This is greatly enhanced by the abundant use of metaphors to depict AIDS which depict it as a foreign and invading agent, rather than something that comes upon us, so to speak, from within. So it easily is represented as something which others, and particular less familiar others have, and is projected onto outgroups.

Other representations include the belief that one cannot get the virus from someone you love. It manifests in communities as the perception that one cannot become HIV infected if one loves the person. HIV comes from outside and this puts the anxiety at bay. Within the South African context this has taken a strong racial and class overtone. So other race and class groups have been received as the primary carriers of HIV/AIDS.

Kelly (2001) argues that in South Africa "AIDS kills" has been an accurate portrayal. It has also been a predominant AIDS campaign message. He contends that the emphasis on the monstrosity of AIDS has made it difficult to address as an issue that occurs within our

lives, relationships, families; and the inevitable guessing game of who and who isn't infected.

This strongly draws attention to the need to reconstruct the thematic and symbolic world of HIV/AIDS as something that needs to be engaged with and managed. The borrowing of the language of AIDS from other domains has been a problem in many different ways. In South Africa AIDS, has for example, been actively promoted as 'the new struggle' in an attempt to foster community mobilisation and to harness the impetus of the Apartheid struggle for AIDS mobilisation. But the attempt to harness the capacities for mass mobilisation against Apartheid in the AIDS struggle is seen as not suited to the uniqueness of the AIDS challenge. Kelly (2001) argues that appealing as it is on one level, the borrowed language does not necessarily lend itself to supporting the kinds of attitudes, dispositions and so on which are necessary for managing the passing of HIV through intimacy, or the caring for someone who is desperately ill.

He points out that we need to understand the symbolic achievements of the languages of AIDS which we use and further that it is important to unpack and understand how the symbolic universe of AIDS works at the level of social response and to appreciate that this cannot be separated from the message.

Denial, he argues, is also supported by an expressed, premature fatalism, based not on projection of the threat of risk, so much as an expression of the reality of there being little to no possibility of meaningful societal support and care, particularly in extremely

hopeless rural communities, where there is a lack of environmental accommodation and opportunity. This he argues, also reflects the social reality that even if one does try to protect oneself, one is still vulnerable. One might be raped or infected by an unfaithful partner, for instance, or infected by a faithful partner by virtue of a previous relationship.

Kelly (2001) thus asserts that the way in which we perceive ourselves as integrated or not into the plans of the broader society, and included or not in its aspirations, seems to have a critical influence on the ability to constructively position ourselves in relation to new risks. He points out that the concept of social capital is a useful concept for capturing this dynamic and further more, social capital is an indicator of the degree to which we are afforded opportunities to participate in determining the conditions which determine our own existence.

Any social development process, according to Kelly (2001) requires the deepening of understanding of the underlying conditions of experience. This process involves taking understanding beyond the commonplace, the everyday, towards understanding motivations, structures of experience, which provides the blueprints for experience. In identifying the hidden authorities of experience we become increasingly capable of making choices and managing situation. If this is necessary, or rather where it is necessary, in the case of AIDS for survival, he argues, the psychoanalytic model of interpretative process may well be useful.

Habermas (cited in Kelly, 2001) sees psychoanalysis as the 'science of reflection'. For him to emerge from psychoanalysis is not specifically to live new meanings, but to be capable of reflecting about one's place in the world and thereby be empowered to act in relation to the conditions of one's existence. Habermas, (cited in Kelly, 2001) locates psychoanalysis as a critical social science and sees self reflection as the foundational operation of critical social science.

Kelly (2001) argues that the gap between knowledge about infection risk and risk avoidant behaviour is the concern. He argues that this problem has given rise to much theoretical development aimed at filling this gap. He maintains that our voices are hardly satisfactory vehicles of the realities that we live, and we need to interpret our self accounts in order to know our worlds. He states, " we need also to consider what knowledge means in the context of HIV/AIDS" (Habermas in Kelly, 2001, p. 11).

What we know from psychotherapeutic experience, he argues is that understanding of ourselves begins with recognition of thematic patterns that link small chunks of behaviour, which link previous disparate experiences. Experiences are broken into bits, much as we live in bits from situation to situation. Interpretations, he argues, about who we are, and what we experience as characters (i.e. across situations), need to be built up inductively. He concludes by stating " we need to unpack and address the small moments of experience, the reality of experience, and on this we might find a more realistic base for changed behaviour" (Kelly, 2001, p. 11).

2.5 CONCLUSION TO LITERATURE REVIEW

In this literature review limitations of individual based approaches to sexual risk reduction based on socio-cultural perspectives and the psychoanalytic perspective were discussed. Much of the literature advocating the use of counselling for HIV prevention is concerned with showing why it is that counselling, as an individualised, non didactic problem solving exercise, is a more effective behavioural intervention than education alone. While these arguments are generally accepted, proponents and critics of VCT and counselling alike have nonetheless criticised what they perceive to be a Western, individualistic and bio-medical model of counselling. These individualistic, self empowerment models of counselling have been criticised as limiting behaviour change through changing people, rather than also changing the contexts they are in. Critics argue that socio-economic and cultural, contextual factors maybe the most important determinants of behaviour, rather than simply being factors which moderate that behaviour (Standing, 1992). The psychoanalytic perspective also provides a perspective that moves beyond rationalistic domains to an appreciation of the emotional worlds and the reality of experiences that influence individual behaviour.

Given that the ARRM model of VCT counselling which has recently been introduced in the South African context is largely based on cognitive individualistic models of behaviour change and given that the client centred TASO model has been found to be inadequate in previous reviews, this research project aims to understand counsellors experiences and perceptions of the use of the ARRM in counselling for sexual behaviour change in the current South African context.

CHAPTER THREE : METHODOLOGY

3.1 Aim

This research aimed to understand VCT counsellors experiences and perceptions of the use of the cognitively oriented ARRM model of VCT counselling for sexual risk reduction in the current South African context.

3.1.1 Qualitative Approach

An interpretive, qualitative research was used in this study given that the research questions aimed to explore the perceptions and experiences of counsellors applying a cognitive behavioural approach to counselling for HIV sexual risk reduction. Qualitative research methods focus on description, understanding and interpretation as opposed to the quantitative approach, which is concerned with numbers and measurements (Kvale,1996). An interpretivist approach with its goal of revealing the participant's views of reality allows the perceptions and experiences of the participants to be elicited. The interpretivist framework was thus used in this study given its potential for understanding the complexities of counselling for sexual risk reduction in the current South African. An interpretivist framework allows for an affirmation of the significance of the participants' knowledge.

The case study approach was appropriate for this research because the research questions posed were of the "how" and "what" type and the focus was on contemporary as opposed to historical events and the researcher had only limited control over actual behavioural events. Qualitative case study methodology allows for greater understanding of a few

cases (Stake,1995). The method was deemed appropriate given that it allows for the development of an in-depth understanding of the uniqueness and complexity of cases and their embeddedness and interaction within context. “We are interested in them (the cases) for both the uniqueness and their commonality. We seek to understand them. We would like to hear their stories” (Stake, 1995, p.1).

Yin (2003) states that, “Case studies are the preferred strategy when “how” or “why” questions are being posed, when the investigator has little control over events, and when the focus is on contemporary phenomenon within some real life context” (p.1).

The focus is on what can be learned from the individual case or cases. Yin (2003) gives the following definition of the scope of a case study : “A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly defined” (p.1).

The case study method was thus utilised in this study to provide an in-depth understanding of participants perceptions of using the ARRM, based on their experiences of using the model and their views as to its applicability for counselling for sexual risk reduction in the current South African context.

3.1.2 The Participants

The participants comprised a sample of VCT Counsellors who had been trained in the client centred, TASO model and the ARRM model. The participants were obtained from a project which is responsible for training VCT counsellors in KwaZulu Natal. The participants provide a VCT service to clients in the midlands of the province of KwaZulu Natal.

A consultation was arranged between researcher, supervisor and the project co-ordinator responsible for training VCT counsellors to discuss gaining access to participants and location of participants. At a later consultation a letter of permission, as well as a letter of informed consent was submitted to the project-cordinator. Permission to interview participants was granted by the project co-ordinaor and the co-ordinator was able to assist in locating dates and times for the interviews to be conducted

3.1.3 Participants Profiles

To protect the identity of participants factitious names were assigned, namely Lungi, Tabita, Gugu and Sma. A brief profile of the participants is provided to convey their individual characters, temperaments, ideas and experiences. All participants communicated in English.

LUNGI

Lungi is a 26 year old, African female who has been a VCT counsellor for six years. She has a tertiary qualification in information technology and a diploma in counselling skills. Lungi has had training in both the TASO Model as well as the AIDS Risk Reduction Model. Lungi states that it was never her intention to become a counsellor, however becoming a VCT counsellor developed an interest in counselling skills. I then became interested VCT for the following reasons :

Extract 3.1

To be honest it started on a voluntary basis, I had a neighbour who was doing peer education in the community, so I decided I would like to participate. Then I became interested in going out there and educating communities, highschoools about AIDS. Then I got more interested in learning about basic counselling skills.

TABITA

Tabita is a 26 year old, African female who has been a VCT counsellor for over three and half years. Tabita has a tertiary qualification in human resource management. Lungi has had training in both the TASO Model as well as the AIDS Risk Reduction Model. She revealed that she enjoys interacting with people and therefore developed an interest in counselling. She states the following

Extract 3.2

At first it was just a job for me. I have a diploma in Human Resource Management and I love interacting with people. I remember this one male client and he came back to me, not once, but many times. I think that counselling is something "new" in rural South Africa. The client said that he was never listened to before. I thought that it was important and I became interested in counselling.

GUGU

Gugu is a 33 year old, African female who is a trained social worker and a VCT counsellor. She has been a VCT counsellor for the last nine years. Gugu has had training in both the TASO Model as well as the AIDS Risk Reduction Model. Gugu states the following as reasons for her wanting to become a counsellor :

Extract 3.3

I can say that I was brought up in a very protected family. We were always well provided for when I grew up I began to be more aware of helping those less fortunate than myself. So I started wanting to make a difference.

SMA

Sma is a twenty nine, year old African female who has a tertiary qualification and has worked part-time as a research assistant for a medical institute. She has been a VCT counsellor for the past two years. Sma has been trained in both the TASO Model as well as the AIDS Risk Reduction Model. Sma states the following as reasons for wanting to become a counsellor :

Extract 3.4

It began with working with working with the Medical Institute, I began doing research as an assistant in the communities.. I began to then see how vulnerable women really are, and how, because of a lack of information, lack of awareness education they really do suffer. So I started so that I could make a difference in working with these communities.

In summary, reasons for wanting to become a counsellor were seen as a useful way of engaging the participants in conversation in the initial stages of the interview. This also helped in developing a profile which lent to a deeper understanding of their individual experiences.

3.1.4 Semi – Structured Interview

Yin (2003) states that “one of the most important sources of case study information is the interview” (p.89). The semi-structured interview using open ended questions was considered appropriate because it provides rich, spontaneous information. It permits the researcher to explore issues and probe into various aspects that are too complex to investigate through quantitative methods (King, 1994). Semi-structured interviews are not constrained by standardization and replicability concerns (Ribbens,1989).

The focus on the interview was on the participants subjective perceptions and experiences of the applicability of cognitive behavioural approaches used for intervention for HIV sexual risk reduction counselling. Semi structured questioning provides the researcher with an opportunity to respond to and follow-up on issues that develop within the interview situation. A semi-structured interview schedule was drawn up to illicit participants perceptions and experiences (See interview schedule, Appendix 3.) All interviews were conducted during June and July 2005. The interviews with participants were tape-recorded and conducted in English. All participants were fluent with the language. The interview duration ranged from 45 – 60 minutes. Each participant was interviewed once.

3.1.5 Research Procedure

Yin (2003) stages of case study research were adapted to this study :

Designing the Interview Questions

The questions designed were informed by a review of the literature on the topic of sexual risk reduction.

Data Analysis

Holstein and Gubrium (1995) explain that a method that is commonly used in the analysis of data from interviews is called a Thematic Content Analysis method, which involves summarising and classifying data within a thematic framework. Qualitatively, Thematic Content Analysis can involve analysis where any kind of communicative content (speech, written text, interviews) can be categorised and classified (Krippendorff, 2004). Thematic Qualitative Analysis enables the researcher to include large amounts of textual information and identify its properties.

This framework provides a structure for the interpretation of qualitative research data so that it is based around emerging themes and concepts. Punch (1998) explains that once the researcher has identified particular phenomena in the data he or she would then group his or her concepts (experiences) around them. This is done to reduce the massive volume of information with which the researcher has to work. The process of grouping these concepts that seem to pertain to the same phenomena is called categorising. Categories

have conceptual power because they are able to pull together around them other groups of concepts or subcategories.

The format to conduct thematic content analysis was as follows :

- 1.) All the transcripts were typed verbatim onto Microsoft Word.
- 2.) The first stage of thematic analysis involved defining the coding unit that was to be coded. Reference was made to particular words, sentences, paragraphs, phrases. The coding unit was dependent on referring to the research questions asked and the aims of the study. In assisting with developing of coding units NVivo software was used to explore how often coding units occurred. NVivo is designed to facilitate qualitative research projects and remove rigid divisions between “data” and “interpretation.”
- 4.) Coding units were then isolated and then assigned to particular categories.
- 5.) Thematic categories, subcategories and their orientation were thus identified.

3.1.6 Reliability and Validity

The reliability and validity of this study was ensured by the implementation of various methods. Triangulation, peer review and audit trailing were three of the methods employed in the study, and will be described in the following sections.

3.1.6.1 Reliability

The term ‘reliability’ “refers to the extent to which findings can be replicated” (Merriam, 2002, p.27) and to which “consistency through repetition can be maintained” (Dey, 1993, p.250). In order for the study to allow for replication, an audit trail was

documented. An audit trail “describes in detail how data were collected, how categories were derived, and how decisions were made throughout the inquiry” (Merriam, 2002, p.27). Detailed account was kept of how the study was conducted and how the data were analysed in order to ensure the reliability of the study.

3.1.6.2 Validity

‘Validity’ refers to the “extent to which an account accurately represented the social phenomena to which it refers” (Silverman, 2000:175). In qualitative research validity is defined by the degree to which the researcher produces observations credible to self, the subjects being studied and the audience of the study. Both internal and external validity are used as guiding concepts in the search for validity throughout this study.

3.1.6.2.1 *Internal Validity*

Internal validity refers to whether or not one is measuring the theoretical construct or trait that one claims to be measuring. Qualitative researchers can attempt to ensure the validity of their studies by means of triangulation and peer review. Triangulation refers to the use of multiple measures (investigators, sources of data, methods, and theories) to explore the sample phenomena (Neuman, 2000).

In light of Merriam’s (2002, p.26) finding that a “thorough peer examination would involve asking a colleague to scan some of the raw data and assess whether the findings

are plausible based on the data”, peer review was used as another strategy that helped ensure the validity of the current study.

3.1.6.2.2 *External Validity*

External validity, also referred to as generalisability, refers to whether or not one’s research findings can be generalised to other situations. In qualitative research generally, and as was the case in this study, “small non-random samples are selected purposefully, and it is therefore not possible to generalise statistically” (Merriam, 2002, p.28). By giving a contextually rich description of the finding in this study, the hope is that others will be able to extract that which is most readily applicable to other studies, settings or populations. The provision of sufficient information should enable others to judge whether the findings are, in fact, generalisable enough to allow for transference to their own studies or settings. This technique has been referred to as case-to-case transfer by Firestone (cited in Merriam, 2002).

3.1.7 Ethical considerations

Informed Consent

Participants were given an introduction to the purpose of the study and a full, non-technical and clear explanation of the tasks expected of them. This allowed them to make an informed choice to participate voluntarily in the study. They were required to sign the informed consent form.

The personal identity of participants was concealed and only summarised group information or anonymous quotations are provided in this report.

(see Appendix, 2 for the statement of consent and confidentiality)

Ownership of all data emanating from the research was vested in the School of Psychology. Once data analysis has been completed, the data collected will be disposed of.

CHAPTER FOUR : RESULTS AND INTERPRETATION

4.1 IDENTIFICATION OF THEMES AND SUB-THEMES

4.1.1. Usefulness of the ARRM Approach

A dominant theme that emerged was that counsellors, based on exposure to the ARRM, view the use of cognitive behavioural approaches as important in changing client's cognitions. This was indicated by the following statement.

Extract 4.1

*The AIDS Risk Reduction Model, really makes them **think**, I mean really **think**. At the end of the day it makes them question what they want to change about their lifestyles.*

Counsellors indicated that it is satisfying observing clients begin to think about their sexual behaviour and understand that they are ultimately responsible. Moving clients to functioning as responsible people, engaging in self questioning was a desired outcome of the counselling relationship.

Extract 4.2

Interviewer : What is the best part of the job for you?

Interviewee : It is definitely when we come to see our clients beginning to take responsibility for their lives.

Counsellors also indicated that this approach allowed for the identification of specific issues that are problematic.

Extract 4.3

I think it is more specific for both the client and the counsellor. I think it is really good, because these clients just come sometimes and they don't want to talk about the real issues, they just want to go around in circles and find they have gotten nowhere in the end. It helps being specific and focusing on what's going on now.

Counsellors indicated that this approach provided them with a structure to work with clients and this made their task easier. Counsellors felt that this structured approach assisted them to make a difference, which was the reason for becoming a counsellor. Counsellors therefore suggested that working with the cognitive behavioural approach assisted with achieving their personal goals of wanting to make a difference.

Extract 4.4

I think that a counsellor, in doing their job, has to question, "am I making a difference?" Because in VCT, the counsellor may just give either a positive or a negative result. That it is not enough.. I think some counsellors don't care to question when clients tell them how they putting their lives in danger. I think that these counsellors are not making a difference at all.

Counsellors reported utilising a variety of cognitive behavioural techniques in their practice. They considered role play as having good potential for effecting sexual behaviour change.

Extract 4.5

.... role play, they may laugh at it, think it is a joke, but you can see them think, and question, "Is that my behaviour?" They begin to question "Is that the way I act?"

Extract 4.6

..... for the first time they are stopping, thinking and reflecting. You know especially one part, where the counsellor summarises how much risk the client is at. For the first time they look at themselves. They are forced to see themselves. They don't often see themselves like this, I mean the amount of risk they are putting themselves in.

Counsellors also indicated that the approach provided the potential for self questioning by clients.

Extract 4.7

... when you start seeing them questioning themselves after you make them think of something. I mean when they start questioning whether what they are doing is wrong or right. We don't expect them to suddenly change their behaviour, but at least we have placed in their mind something that will make them begin to think differently.

Interviewer : Something that can trigger clients' thinking ?

Interviewee : Yah ! to trigger, to begin to make them question. Change I mean is a process, it won't change overnight.

Counsellors also indicated that the cognitive behavioural approach allowed for follow-up and monitoring of clients behaviour.

Extract 4.8

You can also give them tasks that they can go home and practice, something they can take home, and it allows for follow-up of behaviour. At least it makes them begin to think that “Oh! No I haven’t done this. I think follow-up is important for continuity. The counsellor can even refer to something in the past that is effecting the client now.

Counsellors also indicated that working with a problem solving approach was useful in that it facilitated a plan of action for clients.

Extract 4.9

....and at the end of the day, with a concrete realistic plan for problem solving, you know that the client is leaving with something to take with, something that will help them.

Extract 4.10

The advantage in this approach is that through a negotiated plan, the client is taking something with them at the end of the day.

They also indicated that the problem solving component allowed for a more “personalised” approach to intervention. Counsellors suggested that this ensured that intervention for sexual behaviour change was not divorced from the context that clients live in.

Extract 4.11

I think that the problem solving component can be used better if the counsellor makes it more real to the lifestyle or the environment people live in.

Interviewer : Do you mean like to personalise ?

Interviewee : Yes, like to make it more personal to them, more real. So they know what possible reactions they are going to be faced with. The more personal it is for them, the more they can maybe see how they can change.

Counsellors further indicated that working with the client, rather than telling the client what to do made clients feel that they were being listened to and understood.

Extract 4.12

*One of my clients said that **working with the counsellor** was something new to him. He had been for a test previously and said that he only had to listen to the counsellor. With the ARRM, which he had been exposed to, he said that he felt he was being listened to. He therefore came back to me for counselling.*

Counsellors indicated that communication and expression of emotions and feelings were less acknowledged in the African culture. Counsellors however emphasised the importance of getting clients to express their emotions. Counselling they thought provided the “perfect” space to enable clients to “air out” their emotions. They regarded this as crucial for counselling for sexual risk reduction.

Extract 4.13

Interviewer :So you are saying it is effective when they come to the point of expressing of what their risk is, about talking about it ?

Participant :Yes, because now you know that they have thought about it when they express it, when they say it in words, otherwise it is very difficult to know. But I think it is also very important for them to know they have the space to express is important, because in the Zulu culture, something that is something private is not easily talked about because there isn't any space . Making the space, I think it is important. But I also think that it is very hard to get them there, where they are free to express. You do get clients that you can take to this space where they feel free, but not all of them, that's why I say it's one of the better parts of the job.

Counsellors also indicated that they had an important role to fulfil in the community to educate and correct the myths and misconceptions people have. They indicated that the cognitive behavioural approach had good potential to help them in this endeavour.

Extract 4.14

.....that's why I think that we, as counsellors, are important in the community, to make them think about these kinds of issues [referring to sexual risk reduction issues]. To work with changing the myths, beliefs, to make that connection with the way people behave.

Extract 4.15

..... they have the role of educating the community, there are those who test negative, they need to see how much of risk they are putting themselves in. One girl came back to me after her test and she was positive. She said that if only someone told her about the risk she was putting herself in, if someone had only told her, she would have changed. That's why I think there is too little they know in the communities about their risk.

4.1.2 Limitations of the TASO Model (Client Centred Approach)

While the cognitive behavioural approach (ARRM) was seen in a favourable light the client centred approach was seen to be limited. Participants felt that this approach only enabled “information giving,” and ignored the underlying causes for engaging in risky sexual behaviour. Participants also indicated that this approach did not sufficiently enable clients to actively participate in reflecting on their behaviour and developing strategies for behaviour change, thereby facilitating very little behaviour change. They also indicated that it led participants to become dependant on the counsellors to tell them what they should do and how they should behave.

Extract 4.16

What I felt before, in the TASO model, you were just telling the client “do this, and don’t do that.” It was just like the counsellor basically preaching to the client on how to exactly behave without actually understanding what their underlying problem is or are in their lives or in their lifestyles.

Extract 4.17

TASO Model is useless, it is just giving information, advice giving. They, the client, just has to listen and you can’t tell what they are really thinking.

Extract 4.18

I think that the TASO Model just allows for a one way process, like there is only one way of doing things, like the responsibility falls on only the counsellors. The client also needs to be involved in this. I mean, I think things like empathy, you know your basic counselling skills are not really helping, they are not really changing the way people think.

4.1.3 Socio-Contextual Constraints to using the ARRM (Cognitive Behavioural Approach)

Although interviewees indicated that adopting the cognitive behavioural approach in counselling for sexual risk reduction has great potential for bringing about sexual behaviour change amongst clients, a predominant theme that emerged was that counsellors experienced contextual constraints to the success of this approach.

Extract 4.19

It gets really frustrating sometimes, I mean really frustrating. Knowing you are giving them the skills on how to communicate and behave effectively but you know that they just won't because their partners, families and other people won't help. It gets really irritating because they keep coming back to you after four or five sessions and you know nothing is changing. So it can be really frustrating.

Counsellors voiced that it was stressful trying to counsel clients for sexual behaviour change as there were external factors, factors beyond the confines of the counselling room that restricted clients' behaviour. Counsellors acknowledged that as a result they experienced feelings of frustration and despondency about their roles as counsellors.

Counsellors also indicated that while within the therapeutic setting, clients can acquire new skills, related to communication and negotiation they were unsure whether the same clients would use what they have learnt in real situations. Counsellors indicated that they are always left with these feelings of doubt.

Extract 4.20

It may be easier in a one on one counselling situation , with me, a person they don't know, but when they get back home, back to their environment, it could be hard. I would say that the things that make it difficult for them are that their families tend to be very judgmental, they tend to be difficult.

Counsellors also indicated that living in a patriarchal society, where men are dominant also resulted in difficulties experienced by clients in implementing new skills for behaviour change.

Extract 4.21

I think it is difficult for the clients, take for example, condom negotiation. You are dealing with a society and culture where there are unequal power relations and a society and culture that encourages this way of thinking. I think it makes it hard for women to even think about challenging, let alone speaking about it.

Extract 4.22

I think these patriarchal ways of thinking is still something very real and alive. Men are still seen as the powerful ones, making it hard for the woman to approach, even to communicate about safe sex.

Further, counsellors reported that male clients often do not take them seriously as females are not seen as their equals in society. This, they contended, made counselling men for sexual risk reduction, using cognitive techniques (confrontation, challenging) difficult.

Extract 4.23

.....the men clients don't take us seriously, because the men are not used to women directing them, that is something new for them.

Also linked to the issue of the counsellor's gender, were issues of women being traditionally seen as unassertive, less confrontational and passive. They indicated that VCT counsellors themselves, who are predominantly women, also need to confront these issues in themselves and acquire the very skills they expected their clients to practice.

Extract 4.24

I think that's where the problem is with our VCT counsellors, they brush these issues aside and don't make client's aware of their risky sexual behaviour. You can't expect them [referring to clients] to be assertive if the counsellor is not firm in her beliefs. I think that we need to practice more of developing this skill. We also come from a culture where woman were traditionally not assertive. In our training, I think we must spend more time on developing these qualities that we want our clients to develop.

These patriarchal constraints are compounded by women often being financially dependant on men which made it difficult for clients to assert themselves thus constraining behaviour change.

Extract 4.25

It maybe that she is staying with him for economic reasons, for survival, where else can she go. That's why I think things like negotiation skills and communication become less important.

Normative behaviour regarding sexuality was also seen as influencing the way people think about engaging in risky sexual behaviour. Media, they indicated, promotes the act of engaging in risky sexual behaviour by glamorising it.

Extract 4.26

I think the problem of changing the way they think has to do with how promiscuity is glamorised. The men want multiple partners to feel good about themselves. They consider themselves 'less manly' if they are not promiscuous, but yet all the blame is put on women, because they are weaker. They also listen to what is popular, like what they learn from others, but what they may not necessarily believe. Like when they say 'using a condom is like having sex with the wrapper on.'

Counsellors also expressed experiencing difficulties in the use of their home language in their counselling. They indicated that speaking in a language other than Zulu about sensitive issues such as condoms made it easier to talk about these issues for both the counsellor and client, but then they were unsure as to whether the issue was fully understood by the client.

Extract 4.27

You have to be very sensitive, because in even saying the word condom, penis, it is seen as saying something rude. I found that especially saying it in Zulu, you are “hitting” against a very sensitive area. If you say it in Zulu, they don’t like it. Yet, if they say in English, it somehow ‘softens,’ makes it like..... how can I say.. less threatening. Then you are not sure whether they actually get the meaning or not. Yet, if you say it in Zulu, it is seen as something that is rude.

Zulu culture was also argued as playing a negative role for various reasons.

Extract 4.28

Take our culture for example, you know labola. Labola and marriage, its like giving someone the rights to have sex with the wife. Marriage is not seen as something special, as something special, as something sacred. All of these add to everything that encourages HIV. I am sorry to say that about my culture.

On a positive note however, one participant explained that she felt encouraged by youth who are beginning to view culture differently as a result of being focused on the future.

Extract 4.29

The younger group are becoming more objective about their culture, they are choosing to take only what they think is healthy about their culture, I mean the positive, that which does not promote promiscuity. Those are the ones who are thinking about their future, they know about celibacy and practising safe sex.

Counsellors indicated that clients have biomedical expectations of counsellors because counselling is something new in rural South Africa and the only health professional people are familiar with is that of a medical “doctor.” Since clients were unfamiliar with other health professionals, they perceived the role of the counsellor as being similar to that of a doctor. This, they indicated makes counselling for sexual risk reduction difficult as it promotes the expectation of a biomedical approach where the patient is passive and told what to do by the health professional. This is antipathetic to the cognitive behavioural approach which requires the client to be an active participant in reflecting on their behaviour and developing strategies for behaviour change.

Extract 4.30

Interviewer : What do you think clients expect you to do for them ?

Participant : They expect someone to tell them what to do. They expect to listen and someone to tell them. They don't want to play an active role in their counselling. They want you to tell them what to do because you are supposed to know all the facts, all the medical terms, all the biology. They see you as the doctor. I mean you are supposed to know about ARV [Anti-retrovirals], MCT's [mother to child transmission] and on the other hand you are the counsellor.

Interviewer :So you are saying that it is difficult to marry the two, the medical and the counselling part.

Participant : Yes Kamilla, because on the one hand you are working with biology and the medical and on the other hand counselling is about feelings and emotions. I think that it is difficult because

they expect one or the other. I think they know what a doctor is about, they tell you what to do, but a counsellor is something new, they don't know what to expect.

Extract 4.31

They always see you as the professional. When they see that we will be working together and working on a plan together, that they need to be more responsible they become worried, like surprised. They become uncomfortable.

Counsellors also indicated that because counselling is seen as something new in rural South Africa, using counselling techniques such as confrontation and challenging client thoughts was difficult. They indicated that clients may perceive them as being “rude” or “disrespectful” in challenging the way they think and behave.

Extract 4.32

I think that you the counsellor must react to the clients risky sexual behaviour but you also don't want to come across as disrespectful, like you are passing judgment, because, based on my experiences, they think that you are being rude or disrespectful when you challenge the way they behave and act, especially the older ones. So sometimes you just listen and support.

4.1.4 Need for Support and Training

Counsellors indicated that they experienced various limitations in their training which also limited their efficacy. They explained that often clients reveal issues that relate to the past which are impacting on their present sexual behaviour. The difficulty for counsellors then was how to address issues of the past, issues such as rape, abuse which were linked to current behaviour

Extract 4.33

..... how do we help them with dealing with the present issues when they have not dealt with looking at things that have happened in the past, like abuse, rape? Most often, you find that this is the reason they are engaging in risky sexual behaviour. How do you work with this ? They may know it is a danger, but they are too scared to speak about the past, because they have always been weak, vulnerable, they don't say no. It is difficult, we need to deal with the past to work with the present also.

Counsellors also indicated that the current way in which VCT services are provided where counselling is limited to a “once off” session makes counselling for sexual risk reduction difficult as more than one session may be required.

Extract 4.34

....like role play, problem solving are important, but are difficult for the client. They can't be learnt in just one session. Just one session is not enough in VCT counselling But I think it will get easier with time more experience, more training, we will learn.

Counsellors also indicated that they need knowledge of new theories in counselling and that training should not just be a “once of process,” but rather an on-going process so that counsellors could be updated with the latest developments in counselling.

Extract 4.35

We are the first contact that clients have when they come in for the test, that is why I think that it is important that we as counsellors have the most updated information, not only the necessary medical information, but also on different counselling approaches being used. We need to continuously learn more and not think that we may know everything because of just attending one training course.

Counsellors also appear to be at risk of burn-out. They voiced their frustrations when clients did not change their sexual behaviour and seem to take on the responsibility for their clients behaviour.

Extract 4.36

It is so frustrating, really frustrating, knowing that you are teaching them the skills on how to change their behaviour but they just won't change their behaviour. Sometimes it gets you really, really angry.

One counsellor revealed that she experienced difficulties with boundaries with her clients. She indicated that she wanted to play a number of roles (mother, friend, counsellor, disciplinarian) which resulted in feelings of depression and anxiety. This counsellor revealed that she needed an outlet for these feelings. She suggested that

counsellors should be made aware of the possible experiences and emotions they as counsellors may encounter in counselling for sexual risk reduction to normalise counsellors' reactions to clients in the future. Counsellors also indicated that they need the space and time to "air out feelings" they experienced as a result of counselling. They indicated that at present there were no debriefing sessions available to them.

Extract 4.37

I remember this one thirteen year old girl, I felt so bad for her. I found it so difficult to have boundaries with her. I found myself wanting to be her mother, to tell her not to do stupid things on the one hand, on the other hand, to care for her also. I also felt angry with her for putting herself in danger. I could not just feel sympathy for her. But I also knew that this was wrong, empathy is something, as we know is our counselling skill, but I felt it very hard to distance myself, to have boundaries. I wanted to play more than one role in her life. I wanted to be a mother, a friend. I used to take my worry for her home with me.

I felt that I needed to talk to someone about it and I didn't know who to approach.

I felt I needed to get it "off my chest."

Extract 4.38

I think Kamilla, that it is important that we can have some space to go to "where we can deal with these with these things." I mean that it is not just the client that goes away with these hurt feelings. I think debriefing sessions could be useful. Somewhere where we can go and release these feelings.

Counsellors also indicated that they preferred mentorship to supervision. They regarded supervision as having more to do with administrative technical aspects of counselling. This was regarded as superficial. Mentorship was preferred as counsellors associated it with creating a space for debriefing.

Extract 4.39

It is very discouraging you know, there are those outside stressors that you can't control, you have to just to be quiet and listen. You also don't want to be judgemental and act like you don't understand. But the back of your mind you are thinking it, getting frustrated, getting discouraged and feeling unhappy.

CHAPTER FIVE : DISCUSSION AND INTEGRATION OF FINDINGS

5.1 Usefulness of the Cognitive Behavioural Approach

A central finding was that counsellors considered the cognitive behavioural approach as having great potential for effecting sexual behaviour change. They identified several aspects in this regard.

5.1.1. The Cognitive Component

The cognitive component refers to how people think about and create meaning about situations, symptoms and events in their lives and develop beliefs about themselves. Cognitive techniques help people become more aware of how they reason, and the kinds of automatic thoughts that spring to mind and give meaning to things (Grazebrook & Garland, 2005). Counsellors indicated that they thought the role of the counsellor was crucial in changing the way people think and act, especially in relation to dispelling the myths and beliefs in the community that promoted risky sexual behaviour. Counsellors indicated that it was rewarding to observe clients begin to think about changing their sexual behaviour.

5.1.2 Problem Solving Component

Cognitive interventions use a style of questioning to probe peoples' meanings and stimulate alternative viewpoints or ideas. This according to Grazebrook & Garland, (2005), is called "guided discovery" and involves getting clients to explore and reflect on their style of reasoning and thinking, as well as encouraging them to think about

alternatives. Overall the intention is to move away from more unhelpful ways of seeing things to more helpful and balanced conclusions (Grazebrook & Garland, 2005).

Counsellors found this technique useful, indicating that it presented the opportunity for clients to pause and reflect on how much risk they put themselves in. They asserted that observing clients beginning to question for themselves was a gratifying experience. Most often this was observed by the facial expressions of their clients such as expressions of shock or disbelief. Self questioning, they believed, made issues more personal for the client and thus acted as an incentive for engaging in safe sex behaviour. This component of the counselling process facilitated the process of behaviour change to occur within a context that was not divorced from the lives of the client. Counsellors also indicated that including a problem solving component was effective in counselling for sexual risk reduction in that it helped clients to identify specific problems, to order these problems in terms of importance and then to focus on one problem at a time. Helping clients identify specific steps that they might take to implement the solutions into their everyday lives was seen as a desired outcome of the counselling process. Grazebrook & Garland (2005) argues that the benefits of working with a “here and now approach” is that it brings cognitions and beliefs into the current focus of attention (consciousness) and through guided discovery encourages clients to gently re-evaluate their thinking.

5.1.3 The Behavioural Component

Grazebrook & Garland (2005) contend that the behavioural component in the cognitive behavioural approach refers to the way in which people respond when distressed. With

this approach counsellors help people face feared or avoided situations, thereby reducing their anxiety and learning new behavioural skills to tackle problems.

Counsellors indicated that the behavioural component was important. They felt that it is not enough to have the necessary knowledge of how to avoid engaging in risky sexual behaviour. Knowledge, they suggested, should translate into action which should be adapted to the lifestyle and the contexts in which clients are located. They regarded earlier models they were exposed to (TASO model) as advisory and telling the client how to act, but not empowering the client to act. Skills such as role play and assertiveness training were seen in a positive light, providing clients with skills of how to act on decisions.

5.1.4 Collaboration

The collaborative nature of the cognitive behavioural approach where the counsellor and client work together was seen as having a positive impact on facilitating sexual behaviour change. Collaboration is argued by Grazebrook & Garland (2005) to be one of the key factors influencing the effective delivery of CBT. Counsellors indicated that working together (negotiating a sexual risk reduction plan) with the client, facilitated a relationship based on equal partnership and thereby helped move clients to assuming responsibility for their behaviour. As reflected in the results counsellors considered this particularly useful when counselling female clients who have traditionally assumed a passive role in negotiating safe sex practice.

Grazebrook & Garland (2005) also contend that through collaboration, the therapist brings into the relationship skills and knowledge of psychological processes, theories of emotion and techniques that have helped others and which could be useful for the current client. Grazebrook & Garland (2005) argue that the skill of collaboration is important in the sense that therapy is not experienced as something that has been “done” to the client.

5.1.5 Follow-Up and Monitoring Behaviour

Counsellors indicated that follow-up of clients’ initiatives to change their sexual behaviour change was important, particularly to facilitate reinforcement of safe sex behaviour. This highlights the limitations of the current VCT practice of a ‘once off’ session. A ‘once off’ VCT session is seen as having little potential for bringing about sexual behaviour change. The benefits of follow-up/monitoring, according to Grazebrook & Garland (2005) is that it reinforces and shapes the clients participation as well as modifies the treatment procedures as dictated by progress, feedback and collaborative problem solving.

5.1.6 Facilitating Emotional Expression

Counsellors also revealed that they thought getting clients to express their emotions was important in counselling for sexual risk reduction. They indicated that they felt that they were having some impact when their client expressed their feelings and that the counselling relationship facilitated this process. This much desired outcome of counselling was, however, made difficult by what counsellors believed was the

consequence of living in a society or being part of a culture, where males and females concealed their emotions.

5.2 Barriers to using the Cognitive Behavioural Approach in the current South African context

As has been discussed, counsellors indicated that there is good potential for the use of the cognitive behavioural approaches. Equally, however, counsellors reported experiencing various problems in using the approach within the present South African context.

Analysis of the data revealed that contextual factors that pose barriers to counselling for sexual risk reduction include gender power differentials, poverty, differentials in language which limit effective communication, varying cultural practices, relative empowerment and disempowerment of people. Exposure to risk and individual capacity to reduce risk, was thus understood to be moderated by these contextual influences.

With regard to gender issues counsellors explained that living in a patriarchal society, where males are dominant made it difficult for female clients to change their sexual behaviour. These patriarchal constraints are compounded by women being economically dependant on men. Further, it was reported that male clients often do not take the VCT counsellors seriously as the majority of them are female and females are not seen as their equals in society. Male clients were reported to be especially resistant to engaging with female counsellors. Expectations that men are self reliant, self experienced and more knowledgeable than women, inhibit men from seeking treatment, information about

sex and protection against infections, and from discussing sexual health problems from women. Men fear that admitting their lack of knowledge will undermine their manhood (Blanc, 2001; UNAIDS,1999). Further a study by the Perinatal HIV Research Unit, University of Witwatersrand (1996-2005) revealed that men report that clinics are typically “feminine” environments dominated by female staff and clients. Men are therefore uncomfortable coming to these sites for HIV tests and reluctant to discuss their sexual behaviours in such places. Counselling for sexual risk reduction and adherence to safe sex practise is thus made more difficult by these power relations.

It is thus evident from the identification of these factors that challenges facing successful counselling for sexual risk reduction should not only be situated within one on one interaction between the counsellor and the client. Counsellors contended that the anxiety and frustration they experience was most as a result of helping clients develop skills such as condom negotiation, assertiveness but then not knowing whether clients would actually practise these skills in their home environment due to contextual constraints. Counsellors spoke of families being too judgmental and also the difficulties of living in a society where woman have little power to negotiate safer sex.

Counsellors also indicated that they felt helpless to assist clients when they presented with needs related to poverty. This concurs with Lehmann & Zulu’s (2005) study of nurses’ experiences of the HIV epidemic in Cape Town clinics, where they found a recurring theme that nurses increasingly found themselves engaged in extra-ordinary activities in the absence of other kinds of support services such as nutrition support. For

nurses working in severely impoverished areas, nutrition support took on another meaning, as many found themselves giving up their lunches and taking money out from their own pockets to alleviate hunger amongst clients. One nurse reported, “ We even bring clothes from home for the babies. We end up being social workers.” (p.2) This highlights the need for VCT counselling to be located within a multi - sectoral response which should address the associated socio-economic constraints to behaviour change.

Fawcett (2001) elaborates on the need for recognising contextual stressors in the client-counsellor relationship. She argues that a lack of credence given to the broader social, political, cultural and historical contexts that influence and are constitutive of the client-counsellor relationship contributes to tensions within the relationship. This, she contends, signifies the importance of viewing HIV counselling as a part of broader systems activity.

Counsellors also referred to difficulties related to language and counselling for sexual behaviour change. They indicated that clients distanced themselves from speaking in their first language, Zulu, when speaking about sexual behaviour. Counsellors explained that speaking in the first language about sexual behaviour was embarrassing because it was such a private issue in the Zulu culture. Counsellors believed that this proved to be a deterrent for clients confronting and taking responsibility for their sexual behaviour. Using their first language, especially in relation to talking about sex, was seen as being rude, disrespectful and often the reason cited for clients not returning for counselling sessions. This concurs with African Voices (2002) in which respondents reported that “AIDS is related to sex and we don’t like to talk about sex directly.” (p. 4). Speaking in English, about sex, which clients seemed to prefer, was seen to facilitate distance from

sexual issues. The downside of this is that when English was used, the counsellors were unsure whether there was a full understanding of the issues discussed on the part of their clients. The role of language in counselling highlights the importance of looking at how cultures communicate about sex and the implications this has for sexual risk reduction counselling. Moto (2004) however contends that to date there has been a paucity of research in Africa on the words and expressions that are used in discussing sex especially in connection with the HIV/AIDS pandemic.

Counsellors believed that client's expectations for them to operate from within a biomedical paradigm made their job more difficult. They indicated that because counselling in rural South Africa is something new and the main health professionals clients have been exposed to are doctors and nurses, clients generally expected counsellors to play a similar role to a doctor. Interaction within the bio-medical approach is generally characterised by the transfer of information as opposed to the establishment of understanding through dialogue. Communication is conceptualised as a one-way flow (from the health care professional to the client) in which information is used as an instrument to bring about change (compliance) (Verwey, 1998). Clients are thus forced into a position of dependency. Counsellors thus indicated that they experience a lot of pressure to play a similar role.

This expectation of the counsellor to play this expert role made counselling for sexual risk reduction difficult especially when considering that the cognitive behavioural approach demands that the counsellor and client share a relationship based on

collaboration. Counsellors thus indicated that clients are often apprehensive about collaboration given their expectation to be 'told' what to do by health care professionals.

Further, counsellors reported that a "once off VCT session" placed limitations on counselling for sexual risk reduction and addressing mental health issues. They expressed the need to move beyond the two session pre- and post test model of VCT towards a continuum of care and support. This concurs with Freeman (2003) and Van Dyk (2005) who argues that pre- and post test counselling are only the beginning of a continuum of prevention and support and not an end. According to Van Dyk (2005), VCT counselling, education, support and care services should be combined to provide a holistic continuum of HIV prevention and care.

The identification of contextual factors that inhibit HIV/AIDS counselling highlights that individual focused behaviour change counselling interventions are unlikely to achieve widescale, population-level behaviour change on a scale commensurate with the scope of the HIV epidemic. Further, by developing interventions to promote behaviour change in individuals, without addressing these contextual issues constrains the effectiveness of these interventions. Of particular concern are community norms or social contexts of risk which are not supportive of sexual behaviour change. We may be motivating clients to change in counselling interventions only to send them back to a real world where their efforts to enact change will not be supported by peers or their sexual partners (Kelly, 1995).

This indicates the need for multi-pronged strategies for behaviour change. One strategy for influencing the re-negotiation of normative beliefs involves the use of popular opinion leaders (Kelly, 1995). These are well-liked trendsetters within community social networks who visibly articulate, communicate about, and endorse the desirability of risk reduction amongst peer networks. Involving popular opinion leaders or trendsetters within communities is seen as an important and understudied approach for facilitating norm changes with regard to sexual practices within vulnerable populations (Kelly, 1995).

5.3 Support and Training

As evidenced in the findings counsellors indicated that their limited training, burn-out, and issues of boundaries inhibited their effectiveness as VCT counsellors. They indicated the need for ongoing support and further training.

Counsellors indicated that based on their experiences of VCT counselling and counselling for sexual risk reduction, they needed to be more creative and flexible in their counselling. Corey, (1996) also argues that in addition to characteristics such as empathy and warmth, and nonjudgmental acceptance, the counsellor must also be creative and active, have the ability to engage clients in treatment, and be skilled and knowledgeable in the use of cognitive behavioural strategies aimed at facilitating the client's process of self discovery. He also contends that a high level of skill and rapport is required to facilitate the process of self disclosure and establish a collaborative relationship with the client.

Counsellors felt that they needed further training in developing these skills, especially confrontation and assertiveness which they felt were crucial to counselling for sexual behaviour change. This need stems from a recognition that VCT counsellors are mostly women who come from a culture where women traditionally adopt a passive role. This concurs with David (1975) who contends that as result of their socialisation, most women have overdeveloped certain attributes such as warmth, compassion, nurturance at the expense of other attributes equally important for effective functioning; for example assertiveness, initiative, reliance. She contends that these attributes are shaped at early age and are so deeply rooted that it will take tremendous determination to change them. Such behaviours, for example self confidence, assertiveness, autonomy and independence are also incorrectly labelled “arrogance”, “aggressiveness”, “selfishness” and “indifference” (David, 1965). One counsellor questioned the expectation of developing these skills and qualities in clients if the counsellor had not acquired the very same skills.

Counsellors also indicated that they were often confronted with counselling clients whose risky behaviour was influenced by unresolved issues in the client’s past eg, rape, sexual abuse, domestic violence were not addressed. They indicated that these issues made their job difficult as they were not trained to deal with these kinds of problems. They indicated that in the absence of any psychological intervention for these issues, counselling for sexual risk reduction was difficult. Counsellors expressed that not being able to address these underlying mental health problems in VCT counselling resulted in feelings of anxiety and despondency about being able to effectively perform their role as a counsellor. While rates of mental disorder in South Africa are high, access to

psychological and psychiatric services is low, especially in rural areas (Brouard, 2005). He also indicates that there are insufficient mental health practitioners in South Africa to cater for the mental health needs that accompany HIV/AIDS and that much of this responsibility will fall on general health care workers and lay counsellors who are ill equipped to deal with mental health problems (Freeman, 2003).

Richards and Pennymon, (2004) suggest that the role of the HIV/AIDS counsellor is complex and counsellors may have to manage psychological problems that require high levels of skills and knowledge. These authors contend that HIV/AIDS counsellors should ideally have an extensive knowledge base in many areas with a large repertoire of counselling techniques and skills. Given that HIV/AIDS is a chronic illness HIV/AIDS counselling is also psychologically demanding on the counsellors in a way other case scenarios are not. Richards and Pennymon (2004) refer to counsellors in HIV taking on a variety of roles. In the context of limited training this highlights the importance for a referral and support system for VCT counsellors.

Further a multi-sectoral approach calls for the VCT counsellor to be familiar with the resources, services and organisations within the community that would complement his or her own service in promoting health and development. It thus essential that the VCT counsellor establish a well-functioning consultation and referral system. The health care worker should acquaint him or herself with the different services and organisations available. Further there should be a clear referral system within the health care system.

Counsellors indicated that based on their experiences of counselling there was a need for continuous and up-dated information on their practice. They argued that counsellors shouldn't become complacent with the knowledge or training they initially receive. They indicated that this attitude would be doing a disservice to counselling clients. Counsellors also indicated that exposure to recent developments in the field as well as other theories on counselling would be important.

This concurs with Lehmann and Zulu (2005) who argue that once-off training courses, often of very short duration do not suffice to impart the required knowledge and skills that are needed to instil confidence in VCT counsellors. The challenge, according to Lehman and Zulu (2005) is for the development of comprehensive training programmes which include a number of elements : initial training; regular refresher training; on the job mentoring and coaching as well as systematic and regular supervision. Such programmes would allow for a guided acquisition of theory and practice as well as reflection of practice (Lehman and Zulu, 2005).

Counsellors also suggested that they were at risk of 'burn-out'. These findings mirror those of Hlalele (2004) who found that counsellors felt discouraged when patients did not reduce their risk behaviours and saw this as a failure on their part. This is also suggestive of boundary problems with counsellors taking responsibility for their clients behaviours which places an enormous burden on the counsellors.

Van Dyk, (2005) cautions health care workers not to take responsibility for things they cannot help or alter. Because of their personalities (a sense of commitment to the well-being of others), health care workers may find it difficult to set limits to the demands placed upon them and maybe inclined to lose themselves in their work. Confronted by the realities of AIDS, health care workers can become disillusioned, which is often the first step to burnout (Van Dyk, 2005).

Further, in counselling for sexual risk reduction, counsellors also experienced reactions that do not fit those of unconditional positive regard. Counsellors revealed feelings of anxiety, anger and frustration towards clients who were not complying with safe sex behaviour.

Gillman (1991) argues that anger that is not expressed could be turned inwards and, eventually, its cumulative effect could lead to depression. Goodkin (1990) also argues that the most common reactions to counsellors working with AIDS is reactive depression, that means it could be a normal reaction to loss, helplessness in changing the situation, adverse circumstances and how much effort any change requires.

All these issues suggest the need for the development of on-going training, support structures and debriefing sessions for VCT counsellors. Counsellors indicated that they needed support for issues such as coping with feelings of anger and frustration towards non-compliant clients and issues of boundaries and counter-transference which all contribute to burn-out. Counsellors indicated that they needed debriefing sessions to

ventilate these feelings which could also help to normalise their reactions to counselling for sexual risk reduction. Mentorship was also favoured over supervision which they felt had more to do with administrative and practical issues and provided little opportunity for expression of feelings.

Richter et al., (1999) and Van Dyk (2005) suggest that mentorship which involves a supportive and equal relationship without evaluation or assessment is important for the prevention of burn-out among counsellors. Richter et al., (1999) also promote the concept of “spontaneous peer mentoring,” whereby counsellors experience mutual care and support interactions.

CHAPTER SIX : CONCLUSION

A review of the literature on VCT in South Africa revealed that the client centred approach (based on the TASO model) informs much of VCT counsellors training. This approach was seen as offering clients supportive care but largely resulted in advice giving. Further exploration of the topic revealed that, more recently VCT training based on the ARRM (AIDS Risk Reduction Model) has attempted to include a cognitive behavioural component to counselling for prevention of HIV infection. This is in line with the need for VCT programmes in South Africa to be instrumental in preventing HIV infection by facilitating behaviour change (Van Dyk, 2005). Given that this approach is fairly new in South Africa, this study sought to explore the perceptions and experiences of counsellors trained in this approach as to its usefulness for the South African context.

Further, this study was viewed as important considering the lack of qualitative studies exploring counsellors experiences within the South African context. Counsellors need to be consulted if optimum services are to be provided, but they are rarely consulted on their opinion (Rachier et al.,2004).

A central finding in this study was that although counsellors considered the cognitive behavioural approach to be superior to the TASO model for counselling for sexual risk reduction they perceived numerous barriers to its use within the South African context.

Elements of the cognitive behavioural approach that counsellors experienced useful in counselling for sexual risk reduction included changing cognitions (correcting the

misconceptions and beliefs that prevail within communities), the collaborative nature of the approach, problem solving nature of the approach, negotiating a risk reduction plan, assertiveness training and follow-up and monitoring of behaviour. In terms of counselling skills, they indicated that skills such as empathy and positive regard as well as confrontation and assertiveness were important in counselling for sexual risk reduction with the latter two being also important to develop personally in their training as counsellors.

Although interviewees in this study indicated that adopting the cognitive behavioural approach in counselling for sexual risk reduction has great potential for bringing about sexual behaviour change, a predominant theme that emerged was that counsellors experienced socio-contextual barriers to the success of this approach. These barriers ranged from problems such as poverty, unemployment, gender inequities, cultural practices, differentials in language and expectations of the counsellor based on the influence of the biomedical approach. This highlighted the importance of a referral and support system for VCT counsellors. A multi-sectoral approach was seen as important in providing resources that would complement counsellors own service in promoting health and development.

Counsellors also indicated that they experienced various limitations in their training which also limited their efficacy. They expressed a need to move beyond the pre- and post test model of VCT towards a continuum of care and support. Counsellors also indicated the need for continuous and updated training in their practice. They indicated

that combining a risk reduction component was an important addition to VCT counselling, furthermore they indicated that there is a need to expand training programmes to include a wide range of clinical and support skills to instil confidence and strengthen capacity. Counsellors indicated that at the moment, once-off training courses, which are often of very short duration, do not suffice to impart the required knowledge and skills.

Counsellors also indicated that they needed support for coping with feelings of anger and frustration towards non-compliant clients and not dealing with issues of boundaries and counter-transference. They indicated that in dealing with these issues they preferred debriefing and mentorship to supervision.

Despite the identification of various contextual barriers to using the cognitive behavioural approach, counsellors remained optimistic that the approach was useful. As evidenced in this research, these interventions need however to be adapted for differing contexts. Kelly (1995) argues in favour of *cultural tailoring* in the use of cognitive behavioural approaches and counselling for sexual risk reduction. He contends that interventions that showed positive results were typically grounded in theory and culturally sensitive to the unique needs of clients. He further contends that culturally sensitive interventions facilitate risk reduction and should take the unique needs of the community into account.

While the use of semi-structured interviews allowed participants to voice their subjective experiences, resulting in spontaneous information, a limitation of the this study is that this

qualitative approach limited the generalizability of my findings. In this regard, the perceptions and experiences of counsellors were bound to one specific area. What was only accounted for were the experiences of VCT counsellors working within the area of Vulindlela. A comparative study using more than one area would have been useful to increase the validity of my findings.

In conclusion, De Cock, (2002) has the following to say about VCT and counselling

“it maybe fear of AIDS that brings clients into your counselling rooms-but they can leave the counselling session with new knowledge and skills to empower them to have more fulfilling personal relationships with their partners and others, as well as influence the other’s behaviour. This is a considerable demand to place upon counsellors and to satisfy it, they need to be operating at the counselling end of the continuum,” (pp.180-181).

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APPENDICES

APPENDIX 1

CONSENT LETTER TO CO-ORDINATOR OF ORGANISATION

18 March 2005

I am a Masters student in the School of Psychology, University of KwaZulu-Natal. I am seeking your permission to interview counsellors as well as clients at your organisation during the year 2005.

The purpose of which is to provide data for my Masters research dissertation based on counsellors and clients experiences of applying cognitive approaches to intervention for HIV sexual risk reduction.

The aim of the research is to investigate the contextual appropriateness of applying cognitive approaches to sexual behaviour change. The study also seeks to explore counsellors and clients theoretical preferences for counselling for sexual risk reduction.

Interviewee's identity will remain anonymous and demographic information collected will be used only for the purposes of developing a profile of the sample. Only summarised group information and anonymous quotations will be published. Participants will receive an introduction to the purpose of the study and a full, non technical and clear explanation of the tasks expected of them so they can make an informed choice to participate voluntarily in the study.

Enclosed is a copy of the interview schedule to be used.

Yours Sincerely



K.V. Rawatlal (Miss)

APPENDIX 2
CONSENT FORM

University of KwaZulu-Natal
Howard College
Durban
4041

Mini-dissertation : Counsellors perceptions of applying cognitive behavioural counselling approaches to intervention for (HIV) sexual risk reduction

Consent to participate in research

Dear participant we are asking you to take part in this research so that we can investigate the contextual appropriateness of applying cognitive behavioural counselling approaches for HIV sexual risk reduction.

This research will be conducted by Kamilla Rawatlal and supervised by Prof Inge Petersen.

If you agree to participate in this study you will be interviewed on your experiences of being a counsellor and your views as to the suitability of cognitive behavioural counselling approaches for HIV sexual risk reduction. The study will be audio-taped and transcribed by the researcher. On completion of the thesis, the audio-tapes and transcripts will be destroyed.

If you agree to participate, you will be advancing knowledge as to the individual and contextual issues that render cognitive behavioural counselling approaches successful or unsuccessful in facilitating protective sexual behaviour in the South African context.

Your participation is completely confidential. The results will be only summarised group information and anonymous quotations will be published.

If you decide to participate you can withdraw at any stage of the process.

You may ask questions about the study. Kamilla Rawatlal is available on 076 5451998.

Signing your name means that means that you agree to participate in this study.

I,agree to participate in this study exploring counsellors experiences of applying cognitive behavioural counselling approaches to intervention for (HIV) sexual risk reduction. I understand that my participation is entirely voluntary, confidential, and that I can withdraw at any time and that the nature of the research has been explained to me. I can call Kamilla Rawatlal on 076 545 1998.

.....
Signature

.....
Date

APPENDIX 3

COUNSELLORS PERCEPTIONS OF APPLYING COGNITIVE/BEHAVIOURAL COUNSELLING APPROACHES TO INTERVENTION FOR (HIV) SEXUAL RISK REDUCTON

COUNSELLOR INTERVIEW SCHEDULE

1. How did you become a counsellor ? (story)
2. Can you think about a recent client and describe a session to me ?
3. Can you describe what you do in counselling with your clients ?
 - 3.1 What are some of the goals you try to achieve in your counselling sessions ?
 - 3.2 What are the steps you use to achieve these goals ?

4. What role do you think the counsellor plays in HIV prevention ?
5. What role do you think the client should play ?
6. How helpful do you think this approach is for sexual behaviour change ? (AIDS Risk Reduction Model)- Role Play, Effective Communication, Risk Reduction Plan
7. What are some of the difficulties/challenges you have experienced in using this approach ?
8. What are some of the difficulties that prevent you from being successful ?
(Probe for contextual stressors – Culture, Norms, Beliefs)
9. What is best part of the job for you ?
10. What is the most difficult part of the job for you ?
(Probe for support for the counsellor, for the care giver)
11. What personal qualities do you think are important to have in the counselling relationship ?
12. In closing, are there any other issues/comments you would like to make about improving your capacity to help clients coming in for VCT counselling ?

