THE EFFECT THE EXPERIENCES OF VOLUNTEER HIV COUNSELLORS HAVE ON THEIR OWN WELL-BEING: A CASE STUDY

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ERKENNING

My opregte dank aan die onderstaande persone wat tot hierdie studie bygedra het:

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SUMMARY

The effect the experiences of volunteer HIV counsellors have on their own well-being: A case study

The aim of this qualitative interpretive research was to explore the experiences of HIV counsellors and how these experiences influence the counsellors' psychological well-being.

The complexities of the context within which HIV pre and post test counselling occurs form the day-to-day reality of barely trained volunteer counsellors whose task it is to counsel, inform and educate people at grass roots concerning HIV. The guiding question of the current research pertained to the experience of HIV counsellors regarding the influence of their work on their own well-being. A case study design was used. In depth interviews were conducted with nine Sotho speaking HIV counsellors working in primary healthcare clinics in the Sedibeng region of Gauteng. Additional data was collected through observation. Data was initially coded, using axial coding; this was followed by thematic analysis.

The focus was on the psychological well-being of the volunteer HIV counsellors. The data indicated that the participants were not overwhelmed by the many stressors of their challenging occupations. They succeeded in developing their own ways of stress relief especially through practising their spiritual beliefs and other means like participating in community activities and meaningful relationships of significant other. They experienced

personal growth and empowerment in general, but especially in the field of health and sexuality. The female participants were increasingly able to negotiate safer sex. Participants' lives were enriched through amongst others the regard they received from their communities, and being in a position to give information and advice that they gained from the training and exposure to information. The participants experienced feelings of self-worth in that they were able to contribute to their communities and thereby adding meaning to their own existence. It became clear that their character strengths such as wisdom, courage, humanity, justice and transcendence enabled them to function and grow in their difficult situation.

The research highlighted that the inner strengths and virtues of the volunteer counsellors enable them to persist, in challenging work conditions and socio-economic circumstances. Difficulties facing volunteer HIV counsellors that became clear are the lack of support and recognition they have to contend with. It is therefore recommended that more attention should be given by the relevant stakeholders to strengthen the support and to make more resources available to them.

OPSOMMING

Die effek wat die ervaringe van vrywillige MIV-beraders op hul eie psigologiese welsyn het: 'n gevallestudie

Die doel van hierdie kwalitatiewe interpretatiewe navorsingstudie was om die ervaringe van MIV-beraders en die wyse waarop hierdie ervaringe hul psigologiese welsyn beïnvloed, te ondersoek.

MIV-berading voor en ná toetsing vind daagliks teen 'n ingewikkelde agtergrond plaas waar beraders met beperkte opleiding met mense op gemeenskapsvlak moet werk en aan hulle berading, inligting en opvoeding moet gee.

Die rigtinggewende vraag van die studie het gehandel oor die wyse waarop beraders die invloed van hul ondervindings as MIV-beraders op hul psigologiese welsyn ervaar. 'n Gevallestudie-ontwerp is gebruik. Diepte-onderhoude is gevoer met nege Sothosprekende MIV-beraders wat in primêregesondheidsorg-klinieke in die Sedibeng-omgewing van Gauteng werk. Axiale kodering is gebruik in die analise van die getranskribeerde onderhoude wat opgevolg is met 'n tematiese analise.

Die fokus was op die psigologiese welsyn van die vrywillige MIV-beraders. Die data het getoon dat die deelnemers nie oorweldig is deur die vele stressors verbonde aan hul uitdagende beroepe nie. Hulle het daarin geslaag om hul eie maniere van stresverligting te ontwikkel, hoofsaaklik deur die beoefening van hulle spirituele oortuigings en ander maniere soos deelname aan gemeenskapsaktiwiteite en betekenisvolle verhoudinge

met belangrike persone in hul lewens. Hulle het persoonlike groei en bemagtiging in die algemeen, maar veral betreffende gesondheid en seksualiteit gerapporteer.

Die vroulike deelnemers het in 'n toenemende mate daarin geslaag om veiliger geslagsgemeenskap te bewerkstellig. Deelnemers se lewens is verryk deur onder andere die respek wat hulle van hul gemeenskappe ontvang het, en deur in staat te wees om inligting en raad aan hul gemeenskappe te verskaf. Die deelnemers het gevoelens van selfwaarde ondervind aangesien hulle 'n positiewe bydrae tot hul gemeenskappe kon lewer, en daardeur betekenis tot hul eie bestaan kon byvoeg. Dit het duidelik geblyk dat hulle karaktersterktes soos wysheid, moed, menslikheid, regverdigheid en transendensie hulle in staat gestel het om ten spyte van hul moeilike omstandighede te funksioneer en te groei.

Die studie het beklemtoon dat die beraders se innerlike sterktes en vaardighede hulle in staat gestel het om te volhard ten spyte van moeilike werkstoestande en sosio-ekonomiese omstandighede. Die probleme wat die MIV-beraders in die gesig staar is die gebrek aan ondersteuning en erkenning. Dit word daarom aanbeveel dat die betrokke rolspelers meer aandag skenk aan verbeterde ondersteuning, asook aan die beskikbaarstelling van voldoende hulpmiddele aan die beraders.

Chapter 1

Introduction and background to the study

1.1 Introduction

My interest in the effect that the experiences of volunteer counsellors in the human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) field have on their own wellbeing developed and grew over a long period of time. I have worked closely with volunteer HIV counsellors for ten years and was often amazed by their strength, enthusiasm and dedication. The challenges of their work and personal situations perturbed me deeply and I often wondered how each HIV counsellor coped with these difficulties and managed to stay relatively positive and focussed. What was their personal experience of and subjective perspective on their work? My need to understand prompted my decision to undertake this investigation.

My involvement in the field of HIV counselling started 10 years ago when I initially worked as HIV programme coordinator with a Provincial Department of Health, and five years later I fulfilled the same function at the Midvaal Local Municipality in the Sedibeng District. The Sedibeng District Council comprises of the towns Vanderbijlpark, Vereeniging, Sebokeng, Meyerton and Heidelberg. On a daily basis I was confronted with the problems, dilemmas and tragedies that so often accompany working in the field of HIV in general, but also more specifically the difficulties faced by the HIV counsellors.

1.2 HIV counsellors and their context

The HIV counsellors are frequently the front line of the battle against HIV and AIDS, which pose a serious threat to the developing world. Since the 1980s, when the human immunodeficiency virus was first identified, millions of people worldwide have died of AIDS-related illnesses. Especially in Southern Africa, the impact of the pandemic has been devastating. The estimated number of people living with HIV in South Africa was 5,41 million in 2006 (Department of Health South Africa, 2007). Statistics on the prevalence of HIV is obtained every year through the anonymous testing of pregnant women who visit the antenatal clinics of Primary Health Care clinics throughout the country. The national HIV prevalence rate for pregnant women in 2006 was 29,1%. The prevalence in Gauteng Province was marginally higher at 30,8%, but Sedibeng District's prevalence rate of 35% (4,9% higher than the national rate) marks the Sedibeng-district as one of the areas with the highest prevalence of HIV infection in South Africa (Department of Health South Africa, 2007). Indications are that the tide of new infections is not stemmed by the current measures that are in place as the latest HIV statistics reported by UNAIDS show that the number of people in South Africa living with HIV has increased to 5,7 million and that an estimated 350 000 people died of HIV-related illnesses during 2007 (Department of Health, 2007). Clearly, the impact of HIV on the lives of people is becoming more adverse, and with it the demand for counselling and care of the infected and affected, is increasing.

The impact of HIV on our nation is mounting, implying that a growing number of individuals' lives are irrevocably changed by a positive HIV diagnosis, thus the increased need for broad-based educational, counselling and medical services. An essential part of counselling service delivery to people affected by HIV in South Africa, are the Voluntary HIV counsellors working in clinics as part of the Voluntary Counselling and Testing (VCT) Programme of the Department of Health. The aim of the VCT Programme is to ensure that all people have easy access to sites where their HIV status can be tested, and where they simultaneously are able to obtain information on the prevention of infection and the implications of such infection (Richter, 1999). The role and background of HIV counselling in South Africa will be discussed in more detail in Chapter 2.

The HIV counsellors are members of nongovernmental organisations (NGOs), which are organisations established by members of the community. Each of these NGOs is registered as a non-profit organisation and funded on an annual basis by the Department of Health. In Sedibeng, the NGO that provides this service, is Vulamehlo, which consists of a manager, an administrative assistant and six mentors. This organisation contracts one hundred and sixty HIV counsellors who are deployed at the local clinics. The Provincial Department of Health budgets for the volunteer counsellors' remuneration. This is channelled through the NGO, in the case of Sedibeng, through Vulamehlo, who is then responsible for paying the counsellors their monthly stipend from the funds allocated to them by government.

The counsellors undergo 15 days of training, which is aimed at them mastering fundamental information and facts about HIV and AIDS, and basic counselling skills. Subsequently, they are placed at primary health care clinics to do the pre- and post-test counselling with clients. Their duties include follow-up counselling for people living with HIV, and sometimes also for partners or relatives of their HIV-positive clients. These clients either visit clinics voluntarily for testing, or are referred by medical staff from the primary healthcare clinics where the counsellors are based, or professional clinical staff in government and private hospitals makes referrals (Richter, 1999).

My experience over the past ten years of working with HIV counsellors is that after their initial training, these counsellors are mostly left on their own with limited expert support in the form of mentoring while performing their duties. This is a serious constraint, as mentoring fulfils a vital supportive role. A mentoring relationship is crucial, because it provides the counsellor or caregiver (whether professional or lay) with guidance and support within an equal non-judgmental relationship (Van Dyk, 2005). Mentoring not only provides the counsellors with much needed emotional support, but also provides an opportunity for personal and professional development to ensure that the counsellors are able to provide a good quality of service to their clients (Oberzaucher & Baggaley, 2002).

Ideally, mentors should be well-trained and experienced professionals who are consistently available for supervision. In the Sedibeng-district, counsellors do not

receive professional mentoring or any psychological support from trained professionals in a sustained manner. In Sedibeng, Vulamehlo, the organisation responsible for the mentoring of the Counsellors, has six people who are responsible for mentoring and supervising the counsellors. The mentors or supervisors use the terms mentoring and supervising interchangeably. Mentors randomly support voluntary counsellors in small groups, and seldom see a counsellor on a one-on-one basis. The mentors were HIV volunteer counsellors, who themselves had only elementary training before they were contracted to work as mentors. A mentor and a manager of Vulamehlo expressed their concern that no additional or advanced training is provided for the mentors to equip them for their mentoring task (Ms Mathibela & Mr Tshehla, Interview). During a follow-up interview held with the mentor, it was evident the situation had worsened and at that stage no extra funds had been allocated to assist with the mentoring programme. According to the mentor, there was no attempt to mentor, and the mentors merely supervise to ensure that the counsellors report for duty, and to collect the data of clients they had seen. During this interview, she exuded an air of hopelessness and expressed the wish to resign from the NGO and end all involvement in any government sector, because in her view, there is "no progress" (Ms Mathibela, Interview). It is thus clear that even though attempts are made to have mentors available for volunteer counsellors, these mentors are mostly ill-equipped to render this service and to manage the stress that goes with this type of support. The mentors are often in no better a position than the counsellors themselves. Unfortunately this is not only the case in Sedibeng, but it

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is also true of other parts of the country, such as Grahamstown (Nulty, 2003). Yet, the need for supervision and support made available to counsellors of HIV-positive clients, seems to be recognised internationally, and is regarded as a way of enabling the counsellors to cope with the stress they experience in counselling their clients (Kiemle, 1994). Studies conducted on the psychological impact that working with the disaster victims of Hurricane Katrina in the United States of America had on the psychologists and mental health workers, highlighted their vulnerability to vicarious traumatisation and burnout, and stressed the need for screening of their psychological well-being and debriefing (Flory, Kloos, Hankin & Cheely, 2008; Jones, Immel, Moore & Hadder, 2008). If trained psychologists and mental health workers then need supervision and debriefing, would volunteer counsellors not need debriefing even more so?

In the course of my duties, counsellors experiencing personal problems have on numerous occasions approached me. My reflections on these meetings constantly brought me to the same conclusion: counsellors' inability to work through their emotional reactions to their work, due to the lack of support, contributes to their difficulty in managing everyday stress in their personal lives. The emotional burden of working in the HIV field undeniably impacted adversely on their personal lives. According to Van Dyk (2001, p. 76) nothing is more stressful and draining on the caregiver's resources than caring for or counselling patients or clients living with HIV infection or AIDS.

Since the beginning of my involvement in the managing of HIV counsellors, I have had a growing concern about their rudimentary training and subsequent isolation while performing their duties, and that this might have a detrimental effect on their physical and emotional wellbeing. The type of emotional stress experienced by the HIV counsellors can be referred to as compassion fatigue or helper burnout. Studies on the trauma and burnout experienced by lay counsellors in South Africa indicate that these counsellors often suffer from post-traumatic stress disorder and burnout (Bell, 2003; Chandler & Kruger, 2005; Steenkamp, 2005). It is widely recognised that helpers or counsellors who deal with the trauma of their clients, are traumatised themselves, without necessarily being directly exposed to trauma. Compassion fatigue has also been called secondary traumatic stress, because helpers or counsellors have to be compassionate and empathetic on an ongoing basis (Figley, 1995).

Figley (1995) mentions two sources of stress experienced by helpers or counsellors, individual and environmental. Individual stressors include self-doubt, physical and emotional exhaustion, assuming too much responsibility for clients and unresolved personal emotional issues such as those related to having relatives and friends who are infected with HIV or even having to live with HIV themselves (Richter, 1999). Environmental stressors are found in the work in physical and social environments, including client issues such as many HIV clients' resistance to change and take responsibility. Generally, it is not a single

factor that causes distress, but a combination of personal and environmental factors that result in counsellors' difficulty to cope.

Volunteer counsellors of Vulamehlo unfortunately have to contend with a variety of environmental stressors. As mentioned, voluntary counsellors have insufficient training and little support, and in some cases poor working environments that contribute to HIV counsellors' struggle to cope. Their working conditions are often far from ideal. They are not permanently employed staff members with the benefits and security that go with such a position (Richter, 1999). To add to their insecurity, they often do not receive their monthly stipend of R1 000 provided by the Department of Health and administrated by Vulamehlo on time (Ms Mathibela, Interview). Administrative problems sometimes lead to non-payment of stipends for a few consecutive months. Yet, they are expected to continue providing counselling services.

Furthermore, the counsellors are often not regarded as colleagues by the nursing staff they work with, or as staff members by the management of the clinic, with the result that they receive very little cooperation and support from these sources. There are exceptions to this experience, but it does not change the fact the counsellors are not permanently employed staff members with the benefits and security that go with such a position (Richter, 1999).

Given their less than ideal working context and their very difficult and demanding duties, I often marvel at the positivity and tenacity of the volunteer counsellors. I acknowledge that the volunteer counsellors' experience of their work is varied and textured. The difficulties and negative experiences are offset by compensations such as positive emotions and personal growth. This is evident in that many of the counsellors go on doing the work for years, despite the low and infrequent compensation they receive, and other obstacles. What are the subjective experiences of these counsellors, and how do they interpret and find meaning in their everyday interactions in the emotionally loaded HIV/AIDS context?

1.3 The aim of this research

The aim of this research is to understand the experiences of HIV counsellors and to develop insight into their subjective worlds of meaning in order to gauge their psychological well-being (Creswell, 1994). This could only be achieved within a constructivist interpretive paradigm as the subjective experiences of each of the participants were accepted as real. The term paradigm refers to a model or framework within which we explore and understand what we observe (Babbie, 2007). With the help of the participants, a version of their reality was co-constructed.

My research intention and attitude is reflected by the following statement of Spradley as quoted by Kvale (1996, p. 125):

> I want to understand the world from your point of view. I want to know what you know in the way you know it. I want to understand the meaning of your

experience, to walk in your shoes, to feel things as you feel them, to explain things as you explain them. Will you become my teacher and help me understand.

My general aim with this research was to explore the work experiences of HIV counsellors, and the influence thereof on their psychological well-being.

The interviews were guided by specific questions which explored positive and negative aspects of their work experiences and how these experiences impacted on their personal lives and being. Specific questions that guided the interviews are discussed in Chapter 3.

Although detailed information about the research process and adherence to ethical principles will be provided in Chapter 3, I need to state at this point that the participants and I agreed on the use of pseudonyms for all participants.

1.4 Chapter outline

In Chapter 2, the concept of psychological well-being and the effects of counselling on a counsellor's psychological wellbeing are explored by means of a literature study. The focus is also on the important role of volunteer HIV counsellors in the South African Primary Health Care System. In Chapter 3, the research paradigm, methodology and the practical implementation thereof is documented. In Chapter 4, I describe the subjective experiences of the

participants. Chapter 5 covers the conclusions of the research, and gives

recommendations for practical application and for further research.

Chapter 2

Theoretical framework of psychological well-being

2.1 Introduction

My interest in the psychological well-being of volunteer HIV counsellors necessitated me to explore the concept, its theoretical background and underpinning constructs. A succinct discussion of psychological well-being will be provided in this chapter.

2.2 Historical overview

Historically, psychologists concentrated on human weaknesses and the various psychological problems and ailments experienced by individuals. Gradually, psychologists became increasingly dissatisfied with the problem-orientated framework of their discipline, the deficit detecting approach which excluded the acknowledging of people's strengths and resources (Strümpfer, 2005). Seligman and Csikszentmihalyi (2005, p. 5) stated that "psychologists have scant knowledge of what makes life worth living" and Sheldon and King (2001, p. 216) called for an understanding of the fact that, despite all the difficulties, the majority of people manage to live lives of dignity and purpose. This awareness of the somewhat restricted scientific and professional domain of Psychology lead to a "zeitgeist" or time readiness, which resulted in two new sub-disciplines in Psychology, namely that of psychofortology (Wissing & Van Eeden, 1997; 2002) and positive psychology (Seligman & Csikszentmihalyi, 2000). These two sub-

disciplines will be discussed later. They have in common the development of a new approach to science and practice in Psychology, which focuses on people's strengths, optimal functioning, overall well-being, building of positive qualities, and their realising of human potential.

The emerging new approach or paradigm has been met with much interest and enthusiasm, and Wissing and Van Eeden (Van Eeden, 1996) and Seligman and Csikszentmihalyi (2001) acknowledge the outstanding contributions of many authors, mainly from the fields of personality psychology and humanistic psychology, that preceded the new perspectives and accentuated optimal human function providing a foundation for later developments.

2.2.1 Personological perspectives on psychological well-being

The following are but a few of the many perspectives on healthy personality functioning (or psychological wellness) that emerged from the work of prominent personality theorists.

Carl Jung (1875–1961) described optimal development of the personality as centred in attaining the self through individuation (Viljoen, 2003). He regarded optimal development and psychological health as the same concept, and further viewed psychological health as an ideal condition that is not easily reached. Optimal development is reached when the boundaries between the individual and the world become permeable and the person becomes one with the greater whole (Viljoen, 2003).

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The self-concept theory of Carl Rogers (1902–1987) describes psychologically well persons as those who are fully functioning. The mentally well person strives to reach a state of being in touch with self, the world and reality, which is the ideal. Such a person is open to experiences and incorporates these experiences into the self-concept. Rogers believed this to be a life-long process in which wellness is a direction and not a destination (Moore, 2003).

According to Moore (2003, p. 380–382), Rogers regarded the optimally functioning person, or psychologically well person to have the following characteristics:

- an openness to experience;
- an increasingly existential lifestyle;
- increasing organic trust;
- freedom of choice and taking responsibility for their choices;
- creativity in solving life's problems;
- basic reliability and constructive relatedness; and
- a meaningful life.

Victor Frankl's (1905–1998) search for the meaning and purpose of human life resulted in his existential theory. Frankl regards optimal development in a psychologically well person as functioning on a spiritual level (Shantall, 2003).

Shantall (2003, p. 447) deduced the following characteristics of a psychologically well person from the writings of Frankl:

- self-determining action;

- a realistic perception of themselves and their circumstances;

- humour: laughing at oneself;

- future-directedness, having a goal and vision for the future;

- experience work as a vocation;

- appreciation of goodness, beauty and truth;

- respect and appreciation for the uniqueness of others; and

- finding meaning in adversity.

These are some of the theories that contributed to the later developments in positive psychology and the construct of *psychological well-being.*

2.3 Positive psychology and psychological well-being

2.3.1 Definition, development and basic assumptions of positive psychology

Compton (2005, p. 31) quotes the description of positive psychology by Kennon and King as follows:

> It is nothing more than the scientific study of ordinary human strengths and virtues. Positive psychology revisits 'the average person' with an interest in finding out what works, what's right, and what's improving. It asks, 'what is the nature of the effective functioning human being, who successfully applies evolved adaptations and learned skills? And how can psychologists explain the facts that, despite all the difficulties, the

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> majority of people manage to live lives of dignity and purpose?'...Positive psychology is thus an attempt to urge psychologists to adapt a more open and appreciative perspective regarding human potentials, motives and capacities.

Positive psychology therefore studies positive characteristics, institutions and emotions that allow people to do the right things for themselves, their families and communities.

The Second World War had such a traumatic and detrimental impact on humanity, that during the war and for a long time thereafter, psychologists concentrated on psychological pathology and human problems, and on how to prevent and treat these pathologies. The emphasis of this disease model of human nature was thus on human frailties and the detrimental influence of imperfect environments on people. Fortunately, even during this period, there were psychologists who thought about what was 'right' in the lives of healthy people, how people were succeeding in coping with adverse circumstances, and what role their strengths fulfilled (Peterson, 2006; Strümpfer, 2005).

One of the major tenets of positive psychology is emphasising the character strengths contributing to people living the "good life", referring here to a fulfilling and happy life. Compton (2005, p. 7) quotes Seligman's definition of the good life as follows: "using your signature strengths every day to produce authentic happiness and abundant gratification". These positive characteristics or strengths include, amongst others, cognitive strength, emotional strengths, interpersonal

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strengths, strengths that protect against excess and strengths like value clarification and principles of transcendence (Compton, 2005; Peterson, 2006).

2.3.2 Aspects of psychological well-being from a positive psychological viewpoint

The medical model emphasises the treatment of psychological problems, but recently a growing recognition emerged of the importance of assisting people to reach a state of optimal psychological development and psychological well-being. This positive view of health and quality of life is mirrored in the World Health Organization (WHO, 1999) definition of health as a state of physical, mental and social well-being and not merely the absence of disease or infirmity (Meyer, 2003; Wissing, 2000).

Following, is a discussion of some constructs of psychological well-being from a positive psychology perspective:

- **Happiness and subjective well-being**

Happiness is most often the goal of each person, and it can even be said that people desire happiness above all else. Happiness is an indication of subjective well-being, and this personal view of well-being can be measured by a person's evaluation of their state of happiness and satisfaction with life. Absence of neuroticism can contribute to subjective well-being. The six core variables that best predict happiness and satisfaction with life are: "positive self-esteem, sense

of perceived control, extroversion, optimism, positive social relationships and a sense of meaning and purpose in life" (Compton, 2005, p. 48).

- **Positive emotions**

Positive emotions consist of emotions such as enjoyment, happiness and joy. As negative emotions can be regarded as necessary for protection and human survival, positive emotions are necessary to enable people to form lasting relationships, which are also essential for survival (Carr, 2004). Frederickson (2001) developed a "broaden-and-build" model of positive emotions which implies that positive emotions broaden our awareness and then build upon the resultant learning to create future emotional and intellectual resources (Frederickson, 2001). The experience and description of positive emotions may vary among different cultures and even individual people, but the essence of it stays the same.

Positive psychology recognises two ways of obtaining pleasure or positive emotions, namely hedonic and eudaimonic. In different periods, different levels of importance were ascribed to these two principles. Hedonism is based on the principle of seeking pleasure and by doing so avoiding pain at all costs. Based on this interpretation of hedonic pleasure, it was seen as an individual experience of a sensual type of pleasure that does nothing to stimulate personal growth. In contrast to the abovementioned view, hedonic pleasure can also be regarded as experiencing pleasure by being emotionally involved with other people, and

thereby experiencing positive and negative affect in balance with each other (Peterson, 2006).

Eudaimonic happiness is centred in the self and based on the principle of developing one's talents, and then to use these talents for the benefit of other people or society as a whole. Then, from the pleasure derived from these actions, happiness and satisfaction with life is experienced. Despite the contrasts between these two principles, the notion today is to regard both as important elements of happiness. Balance between the two principles lead to psychological well-being (Peterson, 2006).

- **Character strengths**

Positive psychology emphasises the importance of character strengths, like honesty, courage and fidelity as contributing to a person's psychological well-being. No distinction can be made between which strengths are most important, but there is full agreement in positive psychology that they are important. Some character strengths are universally regarded as important, yet there are cultural differences in conceptualising character strengths (Peterson & Seligman, 2004; Peterson, 2006).

Character strengths enable people and communities to reach fulfilment in the sense that the outcomes of these strengths are improvements in their lives

(Peterson & Seligman, 2004). According to Compton (2005, p. 171), in order for human traits to qualify as strengths, they should have the following effects:

- They contribute to fulfilment;

- They are valued in their own right;

- They are celebrated when present, but mourned when lost;

- They are taught to the younger generation by parents and social institutions;

- Parables and morality tales teach them;

- People hold and express them in different degrees;

- They are malleable and learnable; and

- They prompt joyful responses.

Peterson and Seligman (2004, p. 29) ultimately categorised twenty-four human strengths under six main moral virtues:

- Wisdom and knowledge manifest as cognitive strengths entail the acquisition and use of knowledge. Included are creativity, curiosity, open-mindedness, love of learning

- Courage manifests as emotional strengths that allow a person to reach goals despite obstacles. This category includes bravery, persistence, integrity and vitality.

- Humanity manifests as strengths that enable a person to show care for others and form friendships. The strengths in this category are love, kindness and social intelligence.

- Justice manifests as strengths that support healthy community life and includes citizenship, fairness and leadership.

- Temperance that prevents excess and overindulgence manifests as forgiveness and mercy, humility, prudence and self-regulation or self-control.

- Transcendence gives meaning to life and supports belief in the greater universe. It manifests as appreciation of beauty and excellence, gratitude, hope, humour and spirituality.

According to Peterson and Seligman (2004), this classification is not set in stone, and different interpretations can be given to the different categories. It is also possible that the classification could be changed in future and should not be regarded as a complete final product (Seligman & Peterson, 2004).

- **Hope and optimism**

The constructs of *hope* and *optimism* contribute to psychological well-being. Hope for the future stems from an individual's belief that he/she can create realistic plans, and muster enough drive to reach the personal goals set. Hope creates various benefits that contribute to people experiencing positive emotions. The positive benefits of hope include a sense of self-efficacy and self-confidence, the ability to deal with stress more successfully and to enjoy social support (Carr, 2004).

Optimism and hope are closely linked in that both strengthen a person's belief that future goals will be reached through one's actions and perseverance. People with an optimistic outlook on life therefore experience higher levels of happiness and satisfaction with life, and with that greater psychological well-being. A distinction can be made between learned optimism, as used by Seligman, for people that can learn to be more optimistic about life by changing how they explain life events to themselves, and realistic optimism, which is optimistic thinking which is in line with reality (Compton, 2005, p. 51).

- **Forgiveness and gratitude**

Forgiveness refers to the act of forgiving those who have done us wrong, and giving them a second chance (Peterson & Seligman, 2004). Compton (2005, p. 193) defines forgiveness as a "willingness to abandon one's right to resentment, negative judgment and indifferent behaviour towards someone who unjustly injured us". Holding on to anger and resentment about the wrongs of the past, is a stumbling block to the achievement of psychological well-being and can cause ill health. Forgiveness, in contrast, can improve inter-personal relationships and even strengthen our ties to humanity in general (Carr, 2004).

Peterson (2006, p. 145) describes gratitude "as being aware of and thankful for the good things that happen; taking time to express thanks". The difference between personal and transpersonal gratitude is that the former is aimed at a specific other person, while the latter is gratefulness towards a universal or

higher power. Gratitude enhances psychological well-being and, like forgiveness, benefits healthy relationships and healthy societies (Peterson & Seligman, 2006).

2.4 Psychofortology and psychological well-being

2.4.1 Definition of psychofortology

"Psychofortology focuses on the nature, manifestations, patterns, origins, dynamics and enhancement of strengths on individual, group and community levels" (Wissing, 2000, p. 8). It is suggested that the concept is used specifically in the domain of psychological strengths and psychological well-being, health or wellness.

Wissing and Van Eeden (1998) first introduced the concept of psychofortology as the study of human strengths. They developed the concept from the term salutogenesis, as proposed by Antonovsky (1987, as cited by Van Eeden, 1996), and fortigenesis, as introduced by Strümpfer (2005). *Psychofortology* is used as a construct when studying psychological well-being and psychological strengths.

2.4.2 Aspects of psychological well-being from a psychofortology perspective

- **Salutogenesis**

As was mentioned in the previous paragraph, Antonovsky (1987, as cited by Van Eeden, 1996) introduced the term salutogenesis, referring to the origin of health. "Salus" stems from the Latin word for health, and "genesis" is the Greek

word for beginning or origin. According to the salutogenic approach, the construct *sense of coherence* forms the foundation of psychological well-being and consists of both cognitive and emotional components. Sense of coherence refers to the perception people have of reality or a specific situation, rather than how they respond to the situation (Aspinwall & Staudinger, 2003). Antonovsky, as a medical sociologist, was intrigued by the ability of people to stay healthy, despite all the factors in life that could lead to ill health. The focus of salutogenesis is on coping and survival, and therefore differs vastly from the study of stress and ill-health. The emphasis of salutogenesis is thus on coping with stress through "generalized resistance resources" which include strength of ego, financial means and social support (Van Eeden, 1996, p. 16).

Antonovsky further suggests that people are not necessarily either healthy or ill, but that their health fluctuates on a continuum between the two poles of health and disease. The position of their health status at any specific time on the health-disease continuum is influenced by factors like the use of coping mechanisms instead of defence mechanisms, the productive use of affect instead of wasting of emotional energy, and mutual cooperation instead of misuse or abuse of other people (Van Eeden, 1996).

- **Fortigenesis and human strengths**

Salutogenesis concentrates on physical health, and while investigating psychological well-being from this perspective, Strümpfer (1995) experienced the

need to work from a wider perspective and coined the term fortigenesis, which refers to the origin of human strengths. While Antonovsky's approach is centred in physical health, fortigenesis is broader-based and holistic, and is concerned with health or well-being in general, including psychological and social strengths that contribute to overall well-being.

Strümpfer (1995) is of the opinion that the interaction between generalised resistance resources and sense of coherence include more than just physical health. When stressors are experienced, the use of generalised resistance resources leads to a process of developing strengths and increasing sense of coherence, which ultimately lead to, amongst others, the development of resilience, positive self-image and coping mechanisms, which has a positive influence on health in general. Human strengths and fortitude assist people in dealing effectively with life's stressors and that in turn positively influences psychological well-being (Strümpfer, 1995).

Human strengths as such are not enough to provide and ensure psychological well-being; human strengths should be supported by positive environments consisting of positive institutions (formal and informal), which include aspects such as democracy and personal freedom. In order to study human strengths holistically, one should focus on the individual in context (Caprara & Cervone, 2000) as people constantly develop, and throughout life their strengths develop and evolve through personal and social processes (Baltes & Freund, 2003). I

therefore could not study the volunteer HIV counsellors in isolation, concentrating only on their work circumstances, but I needed to maintain a holistic view of each participant as part of an ecology of systems, which includes the individual's personal (own history and personal functioning), interpersonal, family, community and cultural spheres of functioning (Moore, 2003).

- **Resilience**

Peterson (2006, p. 247) defines resilience as "a quality that enables people to thrive in the face of adversity". Resilient persons are generally in good health and easily adapt to stressful events in effective and flexible ways. The components of resilience are hardiness, persistence, goal-directedness, belief in the future, sense of purpose, persistence, and sense of coherence (Peterson, 2006, p. 239). Resilience also refers to the ability of an individual to recover after a negative or traumatic experience, and even show signs of growth and development of strengths. Resilience depends on the presence of individual strength characteristics of the person and supportive relationships in a person's life (Carr, 2004; Peterson, 2006).

- **Coping**

Coping fulfils an important role when it comes to maintaining psychological well-being, as coping can be defined as occurring when a person strives to deal with the stress and negative emotions caused by a negative event (Peterson, 2006, p. 70). There are different ways of coping, namely problem-focused coping when

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the person tries to deal with the negative event, and emotion-focused coping when the person tries to deal with the negative emotional response to an event that cannot in itself be changed. A psychologically-well person will appraise the event and then use appropriate strategies of coping, thus maintaining psychological well-being (Peterson, 2006).

2.5 Theoretical models of psychological well-being

The term psychological well-being, as used in this research, refers not only to the absence of illness/pathology, but also to the extent to which people cope with the stress of everyday living, and their ability to live a meaningful life. Empirical research into the various aspects of psychological well-being has lead to a number of models of psychological well-being that aim to clarify and explain the construct.

2.5.1 Psychological well-being: The perspective of Wissing and Van Eeden

A person who is psychologically well can be regarded as someone who experiences life as satisfying, hopeful and meaningful. Such a person is involved in meaningful relationships, has the capacity to maintain a level of effective well-being in challenging times, and, when necessary, can accept support from others (Wissing & Van Eeden, 2002). Psychological well-being could be conceptualised in terms of optimal affective, physical, cognitive, spiritual, self and social processes.

I will now discuss some of the constructs central to the perspective of psychological well-being of Wissing and Van Eeden (2002), based on their research on the psychological well-being of a multi-cultural group of South African people. They found that psychological well-being could be generally described as having a positive affect balance, a sense of coherence, life satisfaction and the absence of ill-health symptoms, both physically and mentally.

- **Sense of coherence**

The construct *sense of coherence* is central to the salutogenesis model, and refers to the manner in which a person views his world and his role within his world. Antonovsky regards 'sense of coherence' as a personality disposition that is associated with effective coping, health enhancing behaviours, and social judgement. Sense of coherence consists of three components: comprehensibility, manageability and meaningfulness (Strümpfer, 2006; Van Eeden, 1996).

- Comprehensibility refers to a confidence that the stimuli that impinge on one are perceived as making cognitive sense; that there is a certain logic, order and predictability in the occurrence of problems and demands in a person's life

- Manageability refers to the confidence that a person has resources available, within himself and from the social and physical environment to meet demands and address problems

- Meaningfulness, which according to Antonovsky is " the extent to which one feels that life makes sense emotionally, that at least some of the

problems and demands posed by living are worth investing energy in, are worthy of commitment and engagement ..." (Antonovsky, 1987, as cited in Strümpfer, 2006, p. 20)

These components are interrelated and form a dynamic element of the structure of personality, but cannot be regarded as a specific personality trait. Sense of coherence is constant across cultures, and can be regarded as universal (Strümpfer, 2006; Van Eeden, 1996,)

- **Satisfaction with life**

Satisfaction with life is a construct experienced on the subjective level, and is expressed as a component of psychological well-being. People evaluate their lives as satisfactory on a cognitive level based on personally-chosen standards and this is expressed as satisfaction with life in general. Satisfaction with life is therefore not dependent on external factors, but on internal frameworks of reference (Van Eeden, 1996).

- **Positive affect**

In psychological well-being, there is a positive affect balance in which positive feelings predominate over negative feelings. It is necessary to differentiate between positive emotions, which refer to feeling happy and joyful at a specific moment, and positive affect, which refers to "consciously accessible, long-lasting feelings", which do not depend on specific objects (Strümpfer, 2006, p. 146).

The model of Wissing and Van Eeden (2002) also indicates that general psychological well-being includes several functioning sub-systems of the person as a whole, for instance cognitive, affective, inter-personal, self-related, and behavioural components. Psychological well-being in this model represents conceptualisations from both the hedonic and eudaimonic theoretical perspective.

2.5.2 Other perspectives on psychological well-being

Writers like Carol Ryff, Jahoda and Keyes and Lopez suggested different models to conceptualise psychological well-being (Compton, 2005; Peterson, 2006; Prins & Van Niekerk, 2001; Strümpfer, 2006).

A short description of each model follows:

- **Carol Ryff's model**

Carol Ryff (Compton, 2005) introduced the concept of interpersonal flourishing when referring to positive relationships with other people as an important element of psychological well-being. Relationships should involve loving, intimate and enjoyable ties to significant others and also core interpersonal emotions like love and desire, but should also include negative emotions like shame, jealousy and hate. Ryff proposed the six-dimensional model of psychological well-being:

- Autonomy describes a sense of self-determination and personal authority. People experiencing high levels of autonomy can keep their individuality in a social context, and act in a determined and independent manner.

- Environment mastery refers to a person's capacity to manage his own life and immediate environment successfully in order to satisfy own needs.

- Personal growth refers to the extent people experience continuous growth and development, and their individual talents and capabilities are fully utilised.

- Positive relations with others are experienced, and satisfactory relationships are formed on which they rely and that is based on mutual caring and empathy.

- Purpose in life refers to a belief that life, both past and future, has meaning and individuals set goals for the future.

- Self-acceptance consists of a positive evaluation of the self, the ability to acknowledge multiple objects of self and to also accept both positive and negative qualities as a balanced whole of one's abilities.

Ryff regarded interpersonal flourishing as essential to psychological well-being across cultures and time (Compton, 2005; Peterson, 2006; Prins & Van Niekerk, 2001; Strümpfer, 2006).

- **Jahoda's Model**

Marie Jahoda (1958, as cited in Compton, 2005, p. 177) was one of the first writers to move away from the pathogenic model of health, that well-being is an

absence of disease, to a model of positive mental health identifying six concept categories or criteria indicative of a state of positive mental health:

- Attitude towards the self comprises self-acceptance, self-confidence or self-reliance. This criterion can be divided into four subcategories: adequate self-awareness, accurate self-concept, self-acceptance and a positive view of the self.

- Growth, development and self-actualisation. A mentally healthy person will strive towards goals set for the future and to realise potential. This involves the ability to accept challenges in the present in order to attain future goals, and an investment in living through involvement in different pursuits, a concern for other people, and a desire to assist others.

- An integrated personality refers to the balancing of the important aspects of the self that allows for efficient functioning. An integrated personality consists of three components: desires, impulses and needs are balanced with rationality, responsibility and social concerns; a unifying philosophy of life or a sense of purpose is present; and the ability to tolerate anxiety and frustration and to delay gratification.

- Autonomy or independence of social influences and control. This criterion regulates behaviour from within, allowing for independent behaviour. It involves the strength to resist unnecessary conformity.

- Effective perception of reality without a person's own needs distorting perception of other people or situations, thereby being able to see others clearly and honestly and being better able to empathise with them.

- Environmental mastery refers to the ability to adapt successfully to situational demands and expectations. It includes six subcategories: ability to love, ability to work and play, good interpersonal relations, ability to meet demands with a sense of mastery and self-efficacy, ability to use adequate problem-solving strategies and lastly the ability to balance efforts to change the external world with efforts to change one's own psychological world.

Jahoda's perspective had a major influence on writers of texts on psychological well-being (Van Eeden, 1996).

- **Keyes and Lopez's Model**

Keyes and Lopez (Compton, 2005) regard mental health as more than just the absence of mental illness as in agreement with the basic assumptions of positive psychology, but they add that it is also not only the presence of high levels of subjective well-being (Compton, 2005; Strümpfer, 2006). According to Compton (2005), Keyes and Lopez founded their four-fold typology of well-being, which operates on a bipolar continuum from flourishing to languishing, on the following assumptions:

- Flourishing people are high on subjective well-being and low on mental illness. Flourishing is reached when a person overcomes physical,

emotional and social challenges and experiences growth despite these challenges. Keyes regarded this as the ultimate state of well-being.

- Floundering people are low on well-being and high on symptoms of mental illness.
- Struggling people exhibit both high well-being and high mental illness.
- Languishing people show signs of low well-being, but they are also low on mental illness.

Keyes and Lopez (Compton, 2005) worked with the concept 'complete mental health', which they defined as a combination of three types of well-being: high emotional well-being, high psychological well-being, and high social well-being and low mental illness.

They introduced the construct of *social well-being* into the model of psychological well-being. Social well-being consists of components of acceptance, actualisation, contribution, coherence and integration. They further propose that subjective well-being consists of emotional well-being and positive functioning (Compton, 2005; Strümpfer, 2006).

2.6 Cultural diversity and psychological well-being

Caprara and Cervone (2000) refer to various studies that confirm that people from different cultural groups experience life events and phenomena differently. Therefore, the understanding of human strengths varies from one culture to

another, and is influenced by the specific culture's norms and values (Eisenberg & Wang, 2003). Wissing and Van Eeden (2002) found significant differences between the scores of the black and white respondents on indices of psychological well-being. As the participants in this current study are all from an African cultural background, it is essential to attend to the cultural diversity in experiencing life and their perceptions regarding psychological well-being.

Prins and Van Niekerk (2001, p. 80) mention some central themes in the traditional African view of psychological well-being:

- Holism is emphasised in that the African worldview does not distinguish between physical and mental illness.

- Harmony within the community, and between communities and the spiritual protectors in the form of the divinities and the ancestors, is regarded as essential to African well-being.

- The presence of the ancestors in the daily lives of Africans is of paramount importance in understanding their experience of psychological well-being.

- Collectivism forms the core of the African experience; there is no conceptualisation of the person without the community.

Researchers and authors tend to describe psychological well-being from the individualistic western perspective, which emphasises the importance of the individual and ascribes responsibility for actions to the individual, while Eastern and African cultures hold a more collective worldview in which the group and its

interest is regarded as paramount (Viljoen, 2003). There are notable differences between the individualistic and the collectivistic cultural views regarding what the causes of happiness and life satisfaction are (Diener, Lucas & Oishi, 2002). People who hold a collective worldview, value their role within their communities above all else (Caprara & Cervone, 2000). The happiness and well-being of the group is often considered to be more important than that of an individual.

The traditional African philosophy contains the assumption that an individual exists firstly and mostly within (as part of) a community. It is therefore of utmost importance for Africans to be able to exist as active members of the community. In general, people do not function firstly as entities on their own, but as members of an immediate community. Mbiti explains it as follows "The individual can only say: "I am, because we are, and since we are, therefore I am" (Mbiti, 1989, p. 106)

According to Viljoen (2003), this collective existence promotes optimal development and psychological well-being. Being part of a community offers the individual a feeling of security and belongingness which contributes to a feeling of well-being. In traditional African communities, negative emotions such as sadness, hurt and anger are directly expressed through cultural group activities like singing, dancing and oratory (story telling) actions, thus enhancing well-being and limiting pathology that could go hand in hand with repressed negative emotions (Viljoen, 2003). Some of the volunteers interviewed in this research

experienced relief from their stress through participation in community activities, and through conversations with relatives and friends.

Pro-social behaviour is a natural result of the African collectivistic worldview in that a person's value is measured in terms of the contribution the person makes to the community. In order to promote the well-being of the wider community, characteristics like kindness, altruism and the abilities to forgive and be patient are virtues valued by the traditional African worldview (Prins & Van Niekerk, 2001, p. 80). The participants in the research are volunteer workers and their community involvement and contribution can clearly be characterised as pro-social behaviour, which I will discuss in the following section.

2.6.1 Pro-social behaviour

Pro-social behaviour refers to behaviour that is voluntary and intended to benefit others without specific benefit to the person executing the behaviour. Eisenberg and Wang (2003) regard pro-social behaviour as positive human functioning. Altruism is a form of pro-social behaviour and is of special importance in this study, as the participants deliver a service on a voluntary basis with only a small stipend as compensation. The question arises as to the reason for so many volunteers being willing to work in the community. Is it solely to benefit another person or group without any benefit to the self, or are there advantages to the benefactors? According to Batson, Ahmad, Lishner and Tsang (2002), true altruism exists, especially when coupled with a feeling of empathy. Empathy can

therefore be described as a source of altruism. Empathy can be defined as an "other-orientated" emotional response elicited by and congruent with the perceived welfare of someone else (Batson et al., 2002). Phumi, a participant in the study stated: "I am not here for the money; I am here to deliver the message of HIV, so I told myself I have to go on." In the context of the African collectivistic worldview, as affirmed by this statement, it seems true that altruistic feelings do motivate people to work for the common good of others without self-regard, as is the case with the volunteer counsellors in this research.

The psychological well-being of volunteer HIV counsellors is the focus of this research; however, it is important to juxtapose the challenges and difficulties these counsellors face in their day-to-day work and living environments in order to provide a comprehensive picture of the facts pertaining to this research.

2.7 The effect of counselling on the psychological well-being of counsellors

Counsellors provide a valuable service, but it may be at the cost of their own emotional and physical well-being. The stressors affecting the psychological well-being of counsellors will be discussed in the following section, with specific reference to volunteer HIV counsellors.

From a counsellor-centred perspective (directive approach) counselling is described by Lie and Biswalo (1993) as a process of helping someone accept and use information and advice for solving or coping with a problem they experience. However, when counselling is approached non-directively, the focus

changes from prescription to facilitation. Facilitation is a process in which clients are only assisted by counsellors to reach their own decisions; it also includes collaboration regarding the planning of coping strategies (Lie & Biswalo, 1993; Richter, 1999). Throughout my involvement with volunteer HIV counsellors, I have noticed the tendency amongst the counsellors to prefer the directive approach to counselling their clients, although they were mostly trained in the non-directive approach. One of the reasons for this might be a perception of the counsellors that the clients come to them with the expectation that they will solve their problems (Grinstead & Van der Straten, 2000).

Counselling is a skill and art and the main therapeutic instrument of counsellors is their own personality. According to Corey (2001), the counsellor should ideally possess the following personality traits, or at least some of them:

- Effective counsellors have an own identity; know themselves and their aspirations.

- they have self-respect and appreciate themselves;

- they are able to recognise and accept their power;

- they are open to change;

- they are authentic, sincere and honest;

- they can make mistakes, but can also admit it, and

- they respect and maintain boundaries, especially between themselves and their client.

A high level of maturity is therefore required of counsellors. Not only are they required to be aware of themselves and their belief systems, values and emotions, they should also be open and accepting, without prejudice towards clients with different and even opposing belief systems and values to their own. This self-knowledge assists counsellors in maintaining a sense of unthreatened openness, honesty, sensitivity and willingness to be with a client who holds views that conflict with their own regarding controversial issues, for instance religion, sexual orientation and issues of morality, thus averting possible unhelpful clashes. Counsellors are seen as both agents of change and role-models who exhibit the skills and behavioural guidelines that the clients need to acquire in order to grow from dysfunctional to adaptive behaviour (Corey, 2001). Especially in the field of HIV counselling, the modelling role of counsellors is important, because the counsellors quite often live in the community where they work.

Even if counsellors have the above-mentioned traits, they can be negatively affected by vicarious traumatisation. The daily tasks of counsellors entail being with patients who are tested for and diagnosed with HIV, and helping them manage the resulting trauma. In this process, vicarious traumatisation frequently results. As stated in Chapter 1, it is widely recognised that helpers or counsellors dealing with the trauma of their clients, are traumatised themselves, without necessarily being directly exposed to trauma. Baird and Kracen (2006) describe vicarious traumatisation as the harmful changes that occur in counsellors or

helpers' views of themselves, others and the world due to their exposure to the trauma of their clients.

The negative influence of vicarious traumatisation on counsellors can be managed in various ways. During training, attention needs to be given to counselling skills, aiming expressly at teaching trauma counselling skills. Protective structures for counsellors, and specifically lay counsellors, are extremely important to shield and guide them. Adequate supervision and debriefing sessions for counsellors are of the most effective ways of helping counsellors manage their own emotions and also improve their counselling skills. Bell (2003) propagates an approach in which the human strengths of counsellors are concentrated on during training supervision. The work environment should emphasise strengths and not the weaknesses of the counsellors (Chandler & Kruger, 2005; Dunkley & Whelan, 2005). Sexton (1999) emphasises the importance of teamwork as a way of assisting counsellors to deal with vicarious traumatisation. Within the team, opportunities for meetings and discussing problems can be created, where counsellors will support and motivate each other.

According to Bell (2003, p. 518) counsellors who seem to cope better with the stress they experience at work and at home, exhibit the following strengths:

- They have a sense of competence regarding coping, they regard themselves as capable of handling stress and can lower their stress levels

regardless of which coping system they use. This can be seen as a function of self-efficacy, which is a belief in their ability to exercise control.

- They maintain objective motivation. Counsellors with a personal history of violence, and with more subjective reasons for doing the work seem to handle the work-related stress with more difficulty than those whose motivations for doing the work are more objective.

- They resolve personal traumas. Counsellors who reported that they resolved earlier personal traumatic experiences seem to handle stress better.

- They draw on positive role-models for coping. Having examples of family members or co-workers coping successfully with trauma or stress, serve as positive models for the counsellor.

- They have buffering personal beliefs. Counsellors with a personal belief system that is based on positive ways of managing or coping with events, seem to be less stressed.

Counsellors who constantly experience vicarious traumatisation can develop burnout. Maslach (cited in Jansen Van Rensburg, 2006, p. 204), defines burnout as "a prolonged response to chronic emotional and interpersonal stressors on the job." Counsellors with burnout not only experience these negative feelings on a professional level, but also in their personal lives. Burnout, therefore, does not only affect counsellors' professional well-being, but also their personal well-being (Jansen Van Rensburg, 2006).

I will further discuss the experiences of volunteer HIV counsellors in the South African context as reported in various studies.

2.8 HIV counselling in South Africa

During the early 1990s the National AIDS Coordinating Committee of South Africa (NACOSA) initiated HIV counselling in the primary healthcare sector, which mostly deals with HIV infection in South Africa. The aim of the counselling services was to prevent or minimise further HIV infections and to provide care and support to those already infected with HIV (Richter, 1999). According to Richter (1999, p. 153), the Global Programme on HIV and AIDS of the World Health Organization, defines HIV counselling as "an ongoing dialogue and relationship between client and counsellor with the aim of preventing HIV transmission and providing psychosocial support for those infected and affected by HIV and AIDS". Lie and Biswalo (1994) describe the two main aims of HIV counselling as the prevention or reduction of HIV transmission, and the assistance of individuals to come to terms and learn to cope with their HIV positive status and problems associated with it.

With the implementation of the South African Department of Health's HIV counselling programme, attention was given to five specific goals:

- to ensure that all people receive pre- and post-test counselling;
- to develop an extensive network of trained counsellors both within healthcare facilities and in the community at large at non-medical sites;

- to ensure that all counselling is accessible and culturally sensitive;

- to develop and sustain an ethos of confidentiality and support, and

- to integrate counselling into primary health care and all related services (Richter, 1999, p. 189).

Despite the good intentions to establish a comprehensive effective HIV counselling programme, researchers such as Meursing and Sibindi (2000) express concern about the lack or inefficiency of HIV counselling in developing countries, mentioning specifically Africa and also South Africa. They plead for the policy-makers and service managers to give greater priority to the development of counselling services.

At the implementation stage of HIV counselling, health care workers, specifically the nursing staff, primarily did the counselling. This arrangement proved to be problematic and the service was mostly ineffective due to factors such as the heavy workload of the nursing staff, inadequate counselling training, and the lack of recognition and support of the nursing staff in their roles as counsellors. The South African STDs/HIV/AIDS Review (1997) found, amongst other problems, the following limitations: lack of policy guidelines regarding pre- and post-test counselling and HIV testing, counselling being limited to healthcare facilities, the lack of ongoing HIV counselling, including end-stage or terminal counselling, and problems relating to confidentiality (Nulty, 2003; Richter, 1999).

In an attempt to overcome the abovementioned, a lay (or preferably volunteer) HIV counsellor project was started during 1995. The basic outcome of the project was that volunteer workers, reporting to NGOs, were trained as HIV counsellors and deployed at health facilities, especially primary healthcare facilities, to render the HIV counselling service. To further address the problems facing HIV counselling, common national standards were put into place by the Department of Health, HIV/AIDS and STD Directorate to improve the quality of HIV counselling. These included standardised training manuals and regulations, ongoing in-service training programmes, and regular support supervision and mentorship of HIV counsellors (Nulty, 2003; Richter 1999).

As mentioned in Chapter 1, at present, HIV counselling is mainly done by volunteer HIV counsellors, working either full-time or part-time, and in most cases being paid monthly stipends, by the NGO they belong to, with funds allocated by the Department of Health. HIV primary healthcare workers, traditional health practitioners and religious or faith-based workers who are not being paid for the counselling services, also do HIV counselling on a small scale. In the South African context, professional, specialised counsellors normally only deal with HIV positive clients when the latter are referred to the counsellors for mental health problems. The fact is that HIV counselling services in South Africa are delivered by volunteer and community-based counsellors in contrast to Europe and America where most HIV/AIDS counselling services are delivered by specialist counsellors (Green, 1996; Nulty 2003; Richter, 1999).

2. 8. 1 Stressors affecting HIV counsellors

Previously, factors that cause stress to counsellors in general, were discussed. In the following section, attention will be given to stressors specific, although not necessarily exclusive, to HIV counselling.

2.8.1.1 Work-related stressors

The stressors discussed below are mentioned in the studies done by Baggaley, Sulwe, Kelly, Macmillan and Godfrey-Faussett, (1996), Grinstead and Van der Straten (2000) and Nulty (2003). The participants in my study mentioned many of these stressors, which seem to support the findings of previous studies.

Stressors the HIV counsellors have to deal with in the working situation, include stressors relating to the client, such as the client's pain and multiple losses. The HIV-positive client experiences loss in many facets of life: a loss of health, future orientation and sometimes the respect of significant others. These losses have to be contended with together with the debilitating illness and often equally debilitating self-blame. This was my personal experience working with HIV-positive clients.

Another source of major stress is related to confidentiality versus the secrecy which seems to be surrounding HIV. Counsellors have to deal with the difficult situation which occurs when their clients refuse to inform their sexual partners of

their positive HIV status and thereby increase the possibility that the partners might be infected with the HI virus. Assisting the clients with issues of disclosure of their positive status to their partners, relatives, friends and employers can be stressful to counsellors (Grinstead & Van Straten, 2000; Nulty, 2003). This will be discussed in detail in Chapter 4.

I also realised that counsellors experienced stigmatisation for working with HIV-positive clients. Due to the fear for and myths about HIV and AIDS on grassroots level, some counsellors do experience vicarious stigmatisation and may even be regarded as being HIV-positive themselves.

Certain cultural taboos like women not being allowed to discuss sexual matters with men and younger people, and not being allowed to initiate talking about sexual matters with older people, complicate the work of the counsellor and thereby add stress to the work environment (Baggaley et al., 1996).

Another problem facing HIV counselling in South Africa (and Africa as a whole), is the fact that HIV counselling models are generally based on a Western worldview which does not recognise many aspects of the African worldview. Some of the relevant aspects of the African worldview to be considered here are beliefs about sexuality and preventative methods. In the African worldview, the importance of procreation, which in a way ensures "personal immortality" by being remembered by one's children and relatives, outweighs many other

considerations (Van Dyk, 2001), resulting in the resistance to the use of condoms (Grinstead & Van der Straten, 2000). The Western sense of individuality versus the African sense of community or collectivism poses further problems. Western-based principles of counselling prescribe that the counsellor has to maintain an emotional distance from the clients and their problems. This contradicts the collective perspective of deep involvement and demonstration of emotional support, which forms an integral part of the African worldview (Green, 1996; Nulty, 2003).

Western views regarding the causes of illness and death also differ from those of Africa. African culture attributes the causes of illness and death in a complex way to the influence of a third party which might be malevolent spirits, the ancestors or witchcraft (Green, 1996; Richter, 1999; Van Dyk, 2001). Counsellors who attend to their clients in a holistic manner certainly need to take note of their spiritual anguish and pain, however, no training is provided in this regard. The differences between the Western worldview and the African worldview pose problems for and cause stress to the volunteer HIV counsellors. The majority of volunteer counsellors are themselves African and they by and large serve an African community. Thus, the counselling model embedded in the Western worldview is mostly not comfortable for or applicable to either counsellor or client (Green, 1996; Nulty, 2003).

Furthermore, the organisational environment poses certain stressors for the HIV counsellor, for instance lack of support from management, and lack of support and debriefing from allocated mentors. Organisational and systemic issues such as the disregard of healthcare staff for counsellors, while they are supposed to work together in a team, lack of space and privacy for conducting the counselling sessions, and uncertainty regarding their work status, add stress to an already stressful situation (Rohleder & Swartz, 2005).

2. 8.1.2 Personal stressors experienced by HIV counsellors

There are several stressors pertaining to their personal lives that influence the counsellors' well-being and therefore also affect their work performance.

HIV and AIDS can affect volunteer HIV counsellors personally. Due to the magnitude of the HIV pandemic in South Africa, relatives, loved ones or friends of HIV counsellors might often be living with HIV, or might even have passed away due to HIV-related illnesses. The counsellors have to deal with the pain of their clients, but also their own pain and distress, and this without professional support (Grinstead & Van der Straten, 2000; Nulty, 2003).

Counsellors may perceive themselves as being at risk of becoming infected with HIV. Especially female counsellors might be in a situation where they have little or no control over the sexual behaviour of their male partners and they are thereby continuously reminded of and confronted with their own vulnerability to

HIV infection (Nulty, 2003). Counsellors may also be infected with HIV and have to deal with their own trauma as well as that of their clients (Baggaley et al., 1996; Grinstead & Van der Straten, 2000; Nulty, 2003).

There are stressors associated with general living conditions, especially in a developing country, that add to the burden of HIV counsellors and contributing to possible burnout. Poverty, overcrowded and often sub-standard living conditions are very real stressors in the lives of many HIV counsellors. The fact that they are mostly not in full-time employment, thereby not earning a secure salary with general employment benefits, contributes to them experiencing stress in their daily lives (Grinstead & Van der Straten, 2000; Nulty, 2003).

2.8.2 Interventions that can help to alleviate the stress burden on HIV counsellors

Various studies (Baggaley et al., 1996; Grinstead & Van der Straten, 2000; Lie & Biswalo, 1994; Nulty, 2003) recommend interventions that can be instituted to alleviate the stress experienced by HIV counsellors:

- regular group sessions for counsellors under the leadership of an experienced facilitator;
- emotional support provided by a trained mentor to assist with the handling of problematic cases and also personal problems;

- ongoing in-service training that focuses on new developments in the field of HIV, the honing of counselling skills and the enhancement of cultural sensitivity;

- acknowledgement of the work of the counsellors and validation of individuals' valuable contribution by a supportive management team; and

- improvement of their employment status and general working conditions.

However, counselling does not only have a detrimental effect on the well-being of volunteer HIV counsellors. Several studies report positive outcomes that accrue for HIV counsellors from their work (Grinstead & Van der Straten, 2000, Nulty, 2003). Counsellors report that they learned through the counsellor training to take responsibility for their own sexual behaviour. The fact that they could influence their clients and people in their personal lives positively with the information they give to them, is very satisfying. They gain respect in their communities as knowledgeable persons, and working as HIV counsellors leads to increased understanding of themselves and improved problem-solving skills. Finally, their work as HIV counsellors gives them the opportunity to meet with different and diverse people, which increases their knowledge and understanding of people in general.

2.9 Conclusion

Many personal and contextual factors (as set out in the latter part of this chapter) impact on the lives of volunteer HIV counsellors in South Africa. A choice was

made not to focus on how these factors might limit their mental and physical health, but rather to explore the characteristics that help individuals to not plummet into helplessness and hopelessness, but to soar. Therefore, the construct *psychological well-being* was comprehensively discussed from the Positive Psychological and Psychofortology perspectives with the focus on human strengths as the means through which people fulfil their human potential. The constructs *psychological well-being, subjective well-being, positive emotions* and *character strengths* amongst others, were highlighted as representing a more optimistic and holistic approach to human functioning.

Special attention was given to the African philosophy and culture, which emphasises the connectedness between people, and that the value and purpose of individuals are intimately intertwined with their position and functioning in their group. African volunteer HIV counsellors have the satisfaction that they make a valuable contribution to their communities through their pro-social helping and counselling activities. These factors may significantly bolster their subjective feelings of well-being.

Chapter 3

Research design and research method

3.1 Aim of the research

My aim to understand how the participating volunteer counsellors make sense of their work-related experiences and how these experiences affect their personal lives and ultimately their psychological well-being, could only be achieved within a qualitative interpretative research framework.

The participants and I created the meaning of the data as a version of their reality and were therefore all active participants in constructing the reality of the specific research phenomena. In this research I wanted to move beyond description to explanation, therefore to move from "verstehen" (understanding) to "erklären" (explaining) (Henning, Van Rensburg & Smit, 2004, p. 9). Thus, my aim was to explore, describe, understand and ultimately interpret the subjective experiences of the group of volunteer HIV counsellors.

3.1.2 Questions and sub-questions

The specific question I wanted to answer was what the effect of HIV counsellors' experiences are on their psychological well-being.

Derived from the central question, I kept the following questions in mind during the interviews in order to gather data:

- How did you become an HIV counsellor?
- What do you experience as positive in your working situation?
- What do you experience as negative in your working situation?

- How does the counselling affect your personal life with regard to emotions, relationships, sexuality and spirituality?
- What are your future expectations regarding your work?

3.2 Methodology

My inquiry as a qualitative researcher into the social phenomenon of the influence the work of the volunteer HIV counsellors had on their psychological well-being, involved the building of a complex, holistic picture of the experiences of the participants at a specific time and place in space.

3.2.1 Philosophical underpinnings

One of the cornerstones of social scientific theory is to describe the present and not to predict the future. Qualitative research comprises an in-depth inquiry in a natural setting where the participant is allowed freedom of action and expression. The data gathered is therefore assumed to be a true and faithful reflection of the participants' worlds or stories as told by themselves (Babbie, 2007; Creswell, 1994; Gubrium & Holstein, 1997).

The qualitative research methodological paradigm acknowledges the validity of different worldviews and of all individuals' unique realities. A paradigm can be described as a general framework from which phenomena are viewed, understood and explained (Babbie, 2007, p. 32). This paradigm is premised on the ontological assumption that there is not one absolute version of reality, but different versions or constructions as each person or group construct their own reality which is influenced by discourse and social interaction (Babbie,

2007; Guba & Lincoln, 1989). The epistemological assumption that knowledge and meaning are subjectively constructed, underpinned my research (Henning, Van Rensburg & Smit, 2004; Terre Blanche & Durrheim 1999, Terre Blanche, Durrheim & Painter, 2006).

As Gubrium and Holstein (1997, p. 101) state: "interpretation makes reality come alive". As a person's view or construction of reality is influenced by various factors like gender, age, culture and religion, these factors must be acknowledged and integrated into the process of data interpretation.

3.3 Research design
The focal point of study was a group of volunteer counsellors, individuals who share the same work and cultural context thus "a few instances of some phenomenon" (Babbie, 2007, p. 298). This group of individuals can be seen as "a bounded system" (Henning, Van Rensburg & Smit, 2004). Consequently, a case study design was used, which is ideally suited to an in-depth study to answer how and why questions (Babbie 2007; Nieuwenhuis 2007).

3.4 Research process
The meaning of phenomena can be established through various methods: in-depth interviews, the observation of people in their natural settings, and the analyses of texts, words, historical data or artefacts (Henning et al., 2004; Hesse-Biber & Leavy, 2006). I chose to observe participants in their natural setting, to conduct in-depth interviews with participants and to reflectively

include my knowledge of their contexts of functioning as sources of data, to achieve a thick description in which the volunteer counsellor's experiences are interpreted and understood in their complete significant context (Henning et al., 2004; Shank, 2006; Terre Blanche et al., 2006)

3.4.1 Sampling

I work in the same field and geographic area as the participants I invited to participate in my research. I thus made use of convenience sampling (Hesse-Biber & Leavy, 2006; May, 2002; Warren, 2002).

I first held a meeting with fifteen volunteer counsellors working at the clinics in Midvaal. I explained the purpose, reasons for and method of doing the research study, and asked the volunteer counsellors whether they would be willing to participate in the research. The general consensus at the end of the meeting was that they would be willing to participate. I then arranged an appointment with each counsellor to interview him or her individually at the clinic where the participant worked. I interviewed nine counsellors. Of the fifteen counsellors who attended the information session six were not available for interviews. I also had two interviews each with two members of the NGO, Vulamehlo, which is responsible for paying the monthly stipends and monitoring the volunteer counsellors in Sedibeng. I did follow-up interviews with four participants to discuss some of my interpretations of the data with them.

3.4.2 Research participants

I was acquainted with the participants before I started the research and we continued to interact in a specific relationship during the research process. This frequent interaction has proved to be extremely useful as I could maintain closeness to the participants to observe their activities and functioning. In my study I attempted continuously to put myself in the shoes of the participants, to really understand how their work as counsellors influences them in everyday life (Creswell, 1994; Meulenberg-Buskins, 1996), but not to superimpose my views and experiences on those of the participants (May, 2002).

Most of the nine participants are Sotho-speaking as the population we serve are predominantly Sotho-speaking. Eight participants are female and one male. See Annexure 1 for more details on the participants. All the participants were contracted to work in clinics in the Midvaal Local Municipality, which forms part of the Sedibeng Municipal District in Gauteng.

Although the aim of interpretive research is not the generalisation of findings, I believe that due to similar conditions of volunteer counsellors across Gauteng, South Africa, and to a certain extent Africa, the experiences of such counsellors will not differ vastly (Babbie, 2007; Grinstead & Van der Straten, 2000; Nulty, 2003).

3.5 Data collection

I conducted a comprehensive literature review in preparation for the research and also consulted literature on an ongoing basis during the whole research process, in order to deepen my understanding and hone my skills as a researcher. It was a circular process where I did a literature study on methodology and the actual background to the research topic, and then I interviewed the participants, did preliminary data analysis while continuously reflecting on my observations in the light of my research topic and returning to available literature. (Terre Blanche, Durrheim & Painter, 2006; Babbie, 2007). Taylor and Bogdan (1998, p. 140) described analysing as an "intuitive and inductive process which is ongoing during the whole research process."

Iterative process of qualitative research

Literature review

Data analysis

Personal experience

Data accumulation
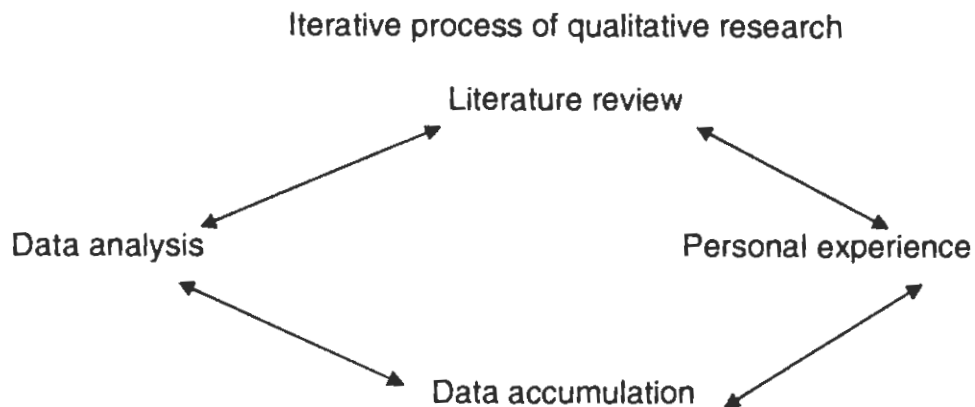
3.5.1 Literature study

I made a concerted effort to read widely and in a focused manner regarding all the key concepts of the study: psychological well-being, counselling and the influence it has on the psychological well-being of the counsellor, traditional African culture and worldview, HIV and AIDS within the South African context and social research methods. The literature study was an ongoing activity which was interwoven with the whole process of the study.

Each section of the process was preceded and followed by the intensive interrogation of relevant literature.

3.5.2 Observation

Due to my involvement with the volunteer HIV counsellors at work, I had the opportunity to observe them in their work environment. I was also in the privileged position to be approached by counsellors regarding various aspects regarding their work and even their personal situations. Before I started with the research, I observed volunteer counsellors in their workplace and my interest in their situation was aroused. During the research, my observations were more purposeful and these have been captured in field notes.

3.5.3 The interview as method of collecting information

In-depth interviewing is invariably about the nature, causes and consequences of a poorly understood or little known social occurrence or phenomenon. The paucity of research on the experiences of volunteer HIV counsellors in the South African context became apparent in my review of literature and thereby confirmed my decision to do this specific research topic. Since psychological well-being was the lens through which I chose to focus my interpretation, my initial source of data was the literature on psychological well-being.

Although I was interested in a specific aspect or event of a counsellor's life, it was necessary to know the person holistically. I conducted the qualitative

interview as a conversation with a specific purpose, but without a rigidly-set standard or questioning format (Babbie, 2007; Shank, 2006).

My focus during the interviews was on obtaining information concerning each participant's thoughts, feelings and actions (Henning et al., 2004; Smit, 2006). I strove to make each interview a purposeful interaction between the participant and myself (Henning et al., 2004; Smit, 2006). The main purpose of my in-depth interviews was to obtain rich qualitative data on the research phenomenon.

Each interview was audio-taped, which I subsequently transcribed. I personally did the transcriptions as soon as possible after the interview, and before I interviewed the next participant.

The observations I made during the interviews were carefully noted in field notes. I kept a separate diary to ensure that at all times, personal opinions, and reflections were kept separate from the data collected. This assisted me in knowing and dealing with my own biases and feelings, and to keep an open mind about how the counsellors experience their work and the influence thereof on their psychological well-being. Although the interviews were done in a relaxed and open manner, I kept the guiding research questions in mind during the interviews in order to gather data for the analysis and interpretation.

I was able to use the information from the literature study to confirm the data I collected through the interviews and my own observations, and to elaborate on it. In this way, the literature study forms an integral part of my study.

DATA COLLECTION

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┌─────────────────────────┐
│ Literature study on     │
│ psychological well-being,│                          ┌──────────────┐        ┌──────────────┐
│ traditional African     │                          │ Observati    │        │ Noted in     │
│ culture,                │                          │ on           │──────▶ │ field journal│
│ social research         │                          └──────────────┘        └──────────────┘
│ methodology, HIV        │       Informs, guides and
│ counselling in the South│       clarifies
│ African context         │                          ┌──────────────┐        ┌──────────────┐
└─────────────────────────┘                          │ In-depth     │        │ Recorded     │
┌─────────────────────────┐                          │ interviews   │──────▶ │ and          │
│ Personal experience and │                          └──────────────┘        │ transcribed  │
│ knowledge               │                                                   └──────────────┘
└─────────────────────────┘
```
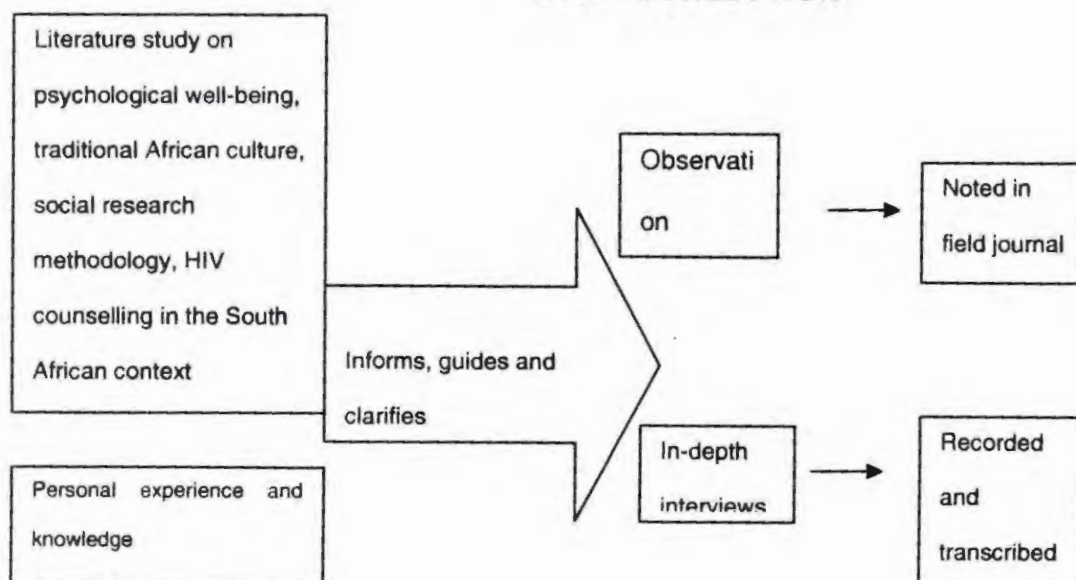
3.5.4 Researcher as research instrument

Throughout my research I was mindful of the fact that the interpretive researcher is the primary research instrument of data collection and analysis (Creswell, 1994; Shank, 2006; Terre Blanche, et al., 2006). As researcher, I therefore needed to recognise that as I influenced the participants, they would also influence me (Van De Laar, 2003). A trademark of qualitative research is the presence and voice of the researcher throughout the research process.

The qualitative researcher needs four basic skills to be successful, namely skills of observation (not just to look and hear, but to be fully aware in a focused way), the skill to converse comfortably, the ability to participate, and interpretation skills (Shank, 2006). I used my skills of observation to really be fully aware, at all times, of what the participants were telling me. I not only

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listened to them, but also observed the emotions they expressed during the interviews. I furthermore attempted to observe and know my own feelings and the context of the situation as a whole. The data was gathered through conversation during the interviews, I therefore used my conversation skills to put the participants at ease during the interviews, to keep my questions in mind, but to strive not to guide or influence their responses through what I said. As I work in the field of HIV, I regarded myself as an active co-participant in the work-life and situation of the HIV counsellors. As a qualitative researcher, I was actively participating in the whole research process with sensitivity to the participants, while being open and eager to learn with them and from them (Babbie, 2007; Shank, 2006). I had to make meaning of the data I gathered through in-depth interviewing and close observation by focusing constantly on the interpretation thereof through the lens of the psychological well-being of the HIV counsellors.

In the process of research, I stayed aware of my observations, informal interactions in the workplace and also my personal reactions, emotions, thoughts and experiences relating to the field of enquiry and these I took down as field notes in a personal diary. My relationship with the participants presented specific demands as I hold specific values and biases and realised that I could not distance myself from these during the research process. In order to counteract this value-laden problem of me being involved with volunteer HIV counsellors for several years in a professional capacity, I had to take extra care during the research to be aware of and separate my own views from those of the participants. I therefore had to maintain a fine balance

between personal involvement and keeping a reflective distance during the research process (Creswell, 1994; Smaling, 1992)

To counteract the influence of my presence as the researcher in the study, I needed to reflect on how my social background (socio-economic position, race, gender, age and upbringing), value system and personal history might influence the choice of study field, developments during the study and the interpretation and outcome of the research. This reflexive analysis formed part of the study, and is reflected in the final written report on the study (Marecek, 2003). Keeping field notes helped me to consciously stay aware of the process of my involvement in the field, with participants and the scientific texts that I studied (Creswell, 1994; Terre Blanche, et al., 2006).

In my reflection on my own position, I realised that I share some of the experiences of the volunteer counsellors. I was trained as an HIV counsellor and have counselled numerous clients. However, as a graduated person in a professional position, I have the benefit of excellent professional training during which I acquired knowledge and developed skills and attitudes that set me apart from the world of mostly poorly-educated volunteer counsellors. My day-to-day reality is also vastly different to that of my participants. I am in full employment and enjoy the security of predictable remuneration and benefits, my role and status is seldom questioned and I live in a comfortable quiet neighbourhood, where I am rarely directly confronted with the realities of my clients' daily lives. In the final instance, I am not personally affected by HIV/AIDS. I thus have the luxury to passionately work in the field without

being burdened by many of the problems the volunteer counsellors'
experience.

I am familiar with the historical background of HIV counselling on both local,
provincial and national level, as well as the organisational, managerial and
training components of the programme. The participants' subjective
experiences of being counsellors, and of their contexts, are unique and
legitimate and can be probed in various ways.

3.6 Data analyses and interpretation

Sources of data were my familiarity with and knowledge of the context within
which the participants live and work, information gleaned from scientific
literature, my observations and in-depth interviews. These data needed to be
synthesised in a textured description of the subjective worlds of meaning of
the HIV counsellors. For the sake of clarity, the process of analysis is set out
in the following schematic representation and will be described in detail in the
following paragraphs. .

DATA ANALYSIS
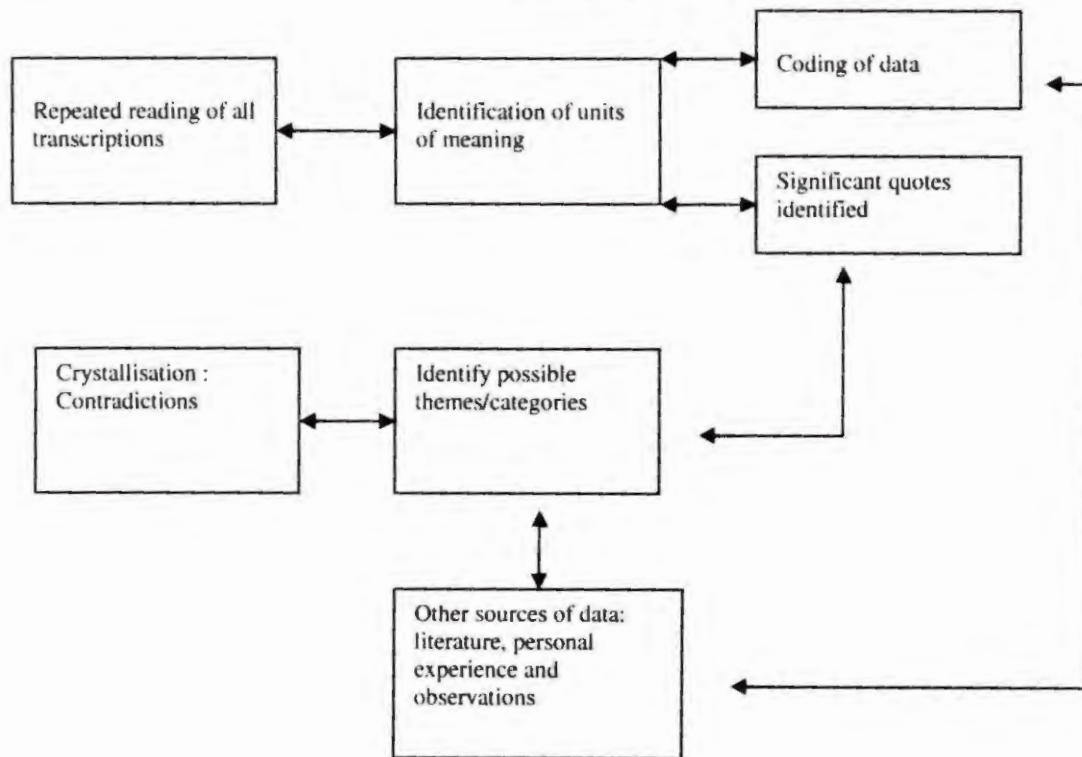
In the analysis of the interview data, I followed a process of "axial coding" (Henning et al., 2004, p. 104) after transcribing the interviews. Initially I read through all the interviews to get an impression of the data. The process of axial coding started with an analysis of the data in which I identified units of meaning (meaning for me as researcher). These meaningful units were captured in short sentences; simultaneously, various meaningful and illustrative quotes were identified and highlighted. This was followed by a process of axial coding, in which similar meaningful units were labelled with a relevant code. Though certain themes seemed to present themselves while I was transcribing the interviews, these were only noted as tentative possibilities, as meaningful themes can only be identified in the light of the whole of the data (Babby, 2007; Dey, 1993; Henning et al., 2004).

I took care not to work with only fragments or parts of the data, therefore I made an effort to understand the meaning of the research data in relation to the whole of the gathered information, which included the theory of psychological well-being, literature on African culture, my observations and personal experience. To create meaning from the data, for myself but also for the reader, the dissected part had to be synthesised into a whole through a process of induction. As a qualitative researcher, I was looking for patterns in regard to my theme to emerge (Babbie, 2007). This I did by categorising or grouping the codes into specific thematic patterns (Dey, 1993; Henning et al., 2004; Hesse-Biber & Leavy, 2006, Hollway & Jefferson, 2000; May, 2002; Terre Blanche, Durrheim & Painter, 2006). Various possible ways of organising the categories presented themselves, but the most meaningful proved to be themes of contradiction.

My aim with the interpretative analysis and writing of the report was to give a thick description of the whole context of the phenomena studied. I realised that the reader was not with me when I went through the processes of the research; I therefore tried to write up every detail as explicitly as possible. I wanted to take the reader with me on the journey of my research. Yet, the writing process was not only aimed at the reader, but also benefited me as I gained clarity on aspects of the context through writing up the progression of the research (Dey, 1993; Henning et al., 2004; Terre Blanche, Durrheim & Painter, 2006). The writing of the research report formed an integral part of the whole research process and I started with it before the final analysis was

done. This granted me the opportunity to edit and re-edit the contents together with my research supervisor until the final product made sense and had meaning for myself and for the reader (Dey, 1993; Henning et al., 2004).

3.7 Quality

It is a difficult task to prove the truth and actual facts in a qualitative research study. The concept of validity, for instance, can be regarded to be "inappropriate" in qualitative research. Criteria that determine the quality of qualitative research are that the research should be well-grounded, justified, thorough and coherent (Kelly, 1999)

3.7.1 Thoroughness

Babbie and Mouton (2001, p. 274) refer to the "trustworthiness" of qualitative data, as a means of determining a study's worth in general. In order to address this, I constantly kept field notes of my observations regarding the context of the research as well as of the interactions, behaviours and informal discussions with participants, their reactions, as well as my own emotions, thoughts and ideas. I integrated these notes in my final analysis and interpretation. I further worked closely with a research supervisor and I discussed my interpretations with four of the research participants to verify my interpretations (Babbie & Mouton, 2001; Hollway & Jefferson, 2000).

3.7.2 Coherence and comprehensiveness

Coherence and comprehensiveness are two of the cornerstones of good qualitative research (Kelly, 1999, p. 434). I strove to give a coherent and

accurate account of the whole research process and to link all the activities into a comprehensive whole. All the parts had to form a consistent and meaningful whole, which culminated in the final interpretation. Coherence and comprehensiveness enhances the value of research and makes findings worthy of adoption by the research community (Kelly, 1999).

3.8 Ethical considerations

I strove to act ethically throughout my research project and to protect the research participants and their settings, neither of which I wanted to be harmed or compromised by the research process (Hesse-Biber & Leavy, 2006). I took as my point of departure the Webster's New World Dictionary definition of "ethical" quoted by Babbie (2007, p. 62) "conforming to the standards of conduct of a given profession or group". Thereby I committed myself to adhering to the ethics or code of conduct relevant to social research in psychology while doing this investigation.

I therefore kept these ethical considerations in mind during the research project from the planning stage through to writing down my conclusions. I tried at all times to adhere to the following generally agreed upon code of conduct guidelines regarding social research in dealing with the participants in my research study:

- The participants gave informed consent to participate in the research by signing a written agreement (attached as Annexure 2). Both the participant and I signed the agreement before I conducted the first interview. The participants were fully informed about the aim,

procedures and possible outcomes of the research during the initial meeting and the subsequent interviews. Consent was continually negotiated during the whole data collecting exercise. During and after the study I ensured that each participant was still willing to continue participation in the research project. I also discussed my conclusions drawn from the interviews with the participants (Babbie, 2007; Hesse-Biber & Leavy, 2006; Hollway & Jefferson, 2000).

- I ensured confidentiality by at all times protecting the identity of the participants. This I achieved by reaching an agreement with them that I would use pseudonyms in the discussion and writing-up of the data collected. All information I obtained was used in such a way that the identity of the individual participant was protected and only known to me as the researcher. Babbie (2007) distinguishes between anonymity when the identity of the participant is known to nobody, not even to the researcher and confidentiality when the interviewer or researcher knows the identity of the participant, but keeps it protected (Hollway & Jefferson, 2000; Hesse-Biber & Leavy, 2006).

- Although there was no significant reason why my research should intentionally cause harm in any aspect physical, psychological or social to any of the participants, I requested participants to inform me immediately should anyone experience feelings of unease or hurt. (Babbie, 2007)

- I treated the participants with respect at all times. I fully agree with the statement of Hollway and Jefferson (2000) that respect for the participant forms the cornerstone of an ethical approach to qualitative

research. I understand respect as an openness for and paying attention to the participant in all aspects, including their emotions and opinions (Hollway & Jefferson, 2000).

I kept to the accepted code of conduct towards the participants in the research, and also attempted to act ethically towards fellow researchers and the institution supporting the research. I strove, while doing the analysis and reporting of the data, to be at all times honest, correct and just. I regard it as essential to report not only on the positive outcomes of the research, but also on the shortcomings and mistakes made during the research. This will ensure that other researchers will learn from this specific research study, even if it is not to repeat the same mistakes (Babbie, 2007).

Chapter 4

Results discussion

Throughout my research, I became more puzzled by how participants manage to maintain certain levels of psychological well-being. It was in the light of this inconsistency that the theme of contradictions crystallised. Identified themes were thus discussed in terms of the interesting contradictions evident in the lives of the participants. Quotes that highlight the themes are combinations of various participants' views expressed in the interviews. The themes are presented in no specific order

4.1 Lack of training, yet participants regard themselves, and mostly act like, professionals

In my day-to-day involvement in the field of HIV counselling, the lack of training, specifically follow-up training, regarding HIV and counselling is evident and the need for advanced training and mentoring was unanimously expressed by the participants in the study.

Although participants received only rudimentary training and a meagre stipend, they do not comfortably rationalise that they do the job as best they can. They actively express their wish for more advanced training as they are sensitive to the complexity of their task. Participants have a need to be informed and knowledgeable so that they can deliver a more professional service to their communities.

> We need advanced training, because we are dealing with people's emotions, like training in psychology. I would like to sharpen my skill.

My impression is that the need expressed by most of the participants to learn more, stems from a deep-seated curiosity, which is classified as strength under the traits categorised under wisdom (Peterson & Seligman, 2004) and also a sense of responsibility to their clients. Some participants have even begun discussion groups for girls to provide a safe forum for girls to discuss sex-related issues, in this their sense of commitment, responsibility and wisdom have inspired them to act far beyond their job descriptions.

Notwithstanding the lack of training, participants regarded themselves as professionals and the work they do as equally important to the work of the nursing staff with whom they work in the primary healthcare clinics. Some expressed the wish that training for HIV counsellors could be coordinated by a professional body to ensure standards of training and to protect the work and enforce an ethical code for all HIV counsellors.

While doing the interviews with the participants, but also working closely with HIV counsellors during the past years, I was often struck by their wisdom and insight in human conditions and their understanding of their specific work environment as well as socio-cultural environment. Mostly their approach to their work is professional and dedicated. Participants showed sensitivity to the needs and problems of their clients, but also demonstrated a surprisingly comprehensive understanding of organisational structures and needs. All participants had clear ideas regarding possible ways to improve service delivery and their own work environment. Suggestions were that the different

Departments, like the Department of Health, Local Authorities and Department of Social Development, should plan a strategy together to address the problems.

> Heads of Departments should come together and do a strategy so that it is possible to reach out there to all those people, like a mobile HIV clinic that is going around, teaching them and bring them to the clinic. ... They must make offices; (now) we are supposed to do counselling outside. We as counsellors we see the problems that are there for those people that are HIV positive

Some participants stressed the communities' need to have health services, and specifically HIV services, available closer to their homes. Their intrinsic wisdom fuelled by intuitive empathy and harsh day-to-day experience, was evidenced by practical knowledge and creative solutions to problems and good judgement, which enables them to make sense of their realities (Peterson & Seligman, 2004).

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The participants maintained their psychological well-being despite the various detractors, because they succeeded in grabbing the opportunity of growth their positions as HIV counsellors gave them. Their training and work have changed them – they perceive themselves as skilled and empowered. This ability to utilise the opportunities for training and personal growth that they got through their work, probably stemmed from strengths such as wisdom and the related constructs of 'love of learning' and 'creativity' (Peterson & Seligman, 2004).

4.2 Lack of mentoring, but they mostly manage to cope with the stressors

I had expected that the lack of mentoring would be a major factor influencing the well-being of the participants, because in my interaction with volunteer counsellors the need for mentoring has been a recurring theme. During the interviews, the participants insistently expressed the need for support or mentoring.

> A problem is that we the counsellors also need to be counselled, we meet different problems with the patients, so that we need to be counselled. When I had the bad influence it was when you don't have a mentor

The need for emotional support and debriefing by counsellors, professional or volunteer, including all people working in a helping profession, is generally accepted and proven by studies worldwide (Chandler & Kruger, 2005; Dunkley & Whelan, 2006; Heyns, Venter & Esterhuyse, 2003; Jansen van Rensburg, 2006; Jones, Immel, Moore & Hadder, 2008). The questions thus emerged as to what the effect of this lack of mentoring would be and how participants manage their work-related stressors and emotions.

Faith provides a transcendent dimension to their task to counsel people living with HIV - they believe they are called by God. Being in the service of God and their community, adds meaning to their lives and satisfies the need to contribute to the collective well-being of society, fulfilling the Ubuntu principle. Spirituality as strength includes religiousness, faith and purpose or

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meaningfulness. Peterson and Seligman (2004, p. 600) describe spirituality as "beliefs and practices that are grounded in the conviction that there is a transcendent dimension of life". People motivated by spiritual beliefs do things toward a greater goal than just their own lives, and thereby find value and meaning in life. Spiritual beliefs influence the decisions people make in life, the relationships they form and the meanings they construct (Peterson & Seligman, 2004).

Religious coping is prominent. People who are religious and have few other non-religious alternatives and resources available, turn to religion to help them cope. All religious coping have the same end – the enhancement of meaning (Pargament, 1997).

> God needed me to be in this position, in order for me to talk to other people. God wanted me to do something, to accomplish a certain mission. I believe if you ask, God will give you what you need. He will give you something you can handle... When I am in church, it is when I am debriefing.... God will help... When a client tested positive and I felt bad about their results, so, when I am home I pray, so that God can give me the strength.

It became clear from most of the participants that relief of stress and emotional turmoil is gained by practising the rituals of their faith. Rituals like church attendance and singing as well as personal spiritual practices play a very important role. Private prayer is also a powerful tool for relieving stress and unburdening emotions.

A sincere childlike belief in God being in control and providing in his children's needs eases the burden of frustration and stress the counsellors carry. Not only does God help them with their work, but God also helps the people who live with HIV to face their diagnosis and future life. The belief in God as being in control and caring about a person opens a path to meaning in suffering

Participants tend to communicate their beliefs with their counselees and hope to alleviate their burden by showing them that God provides strength and is ultimately in control. Should counselees so desire, they pray together during the session, bolstering the faith of both counselee and counsellor. Spirituality therefore plays a very important role as a coping mechanism; it strengthens and supports them emotionally (Steenkamp, 2005).

Participants developed other, unique ways and systems of stress relief. This human strength enables individuals to find relief that suits their own personalities and needs. Activities like singing, visiting with friends, consumerism and talking to other people, such as co-counsellors and friends, are ways participants use to relax and relieve stress.

A major source of support is loving relationships with significant other persons in the participants' lives; it may be relatives, friends or life partners. All participants testified their strong bonds with significant others. Such close relationships enhance the quality of life and help people manage stress better than people who live in social isolation (Peterson & Seligman, 2004;

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Strumpfer, 2003). The ability to love and form meaningful relationships, as psychological strength, played a major role in maintaining a sense of well-being.

4.3 Lack of official recognition in the workplace, versus recognition and regard from their communities.

When I started with the research, I expected the financial constraints to be the biggest source of stress for the participants, but I concluded from the participants' narratives that their biggest need is for permanent appointments, ensuring job security and the implied recognition. Participants unanimously expressed the wish to be employed by the Government sector rather than a NGO and to be involved in decision-making processes.

> If government recognises us, could make a position, so that you could be permanent in this HIV. If only government could invest more in us counsellors. They are investing in the programme, but they are forgetting about the people that are rendering the service ...We don't have a relationship with the sisters, the counsellors are counsellors finish and "klaar", we don't work closely.

My own observations over the years were that in general the clinical staff regarded the counsellors with little respect and as if they were in the way and obstructing the nursing staff in performing their duties, which the nursing staff regard as more important than the counselling.

One might expect that the above might cause the participants' to perceive themselves negatively, yet that is not the case. A reason for experiencing a

feeling of self-worth could be understood against the background of high unemployment in their socio-economic circumstances, and nevertheless they managed to have a job, even though it is a volunteer position with low and uncertain income, there is a certain prestige attached to it.

> Since I am a counsellor I learned something about HIV. I know how to work with people. All the skills I have learned have made me a very powerful person. Before that I wasn't working. I was staying at home doing nothing ... I was very shy, and I couldn't talk to people. Now people believe in me and they come to me for advice.

Because of their training as volunteer counsellors, the participants are regarded by their communities as valuable members of the community who are informed and knowledgeable on health and related matters. Participants are consulted by members of the community seeking information and assistance regarding personal matters and problems, thereby acknowledging the volunteer counsellors as leaders in the community.

Many participants described the satisfaction they experienced in feeling needed and how this adds meaning to their lives. This contributes to greater psychological well-being. Being able to contribute to the community, is of special importance within the context of the traditional African collectivistic worldview in which the emphasis is on the role of the individual as contributor to the collective well-being. It is therefore of utmost importance for the individual from an African context to be able to exist as an active member in the community. In general, a person does not function firstly as an entity on her/his own, but as a member of an immediate community. "The individual

can only say: "I am, because we are, and since we are, therefore I am" (Mbiti, 1989, p. 106).

Generally participants experience being respected by their community, who regard them as knowledgeable regarding health, and related issues. Community members consult them after hours at their homes about other health issues, socio-economic and various practical service-related problems. Being acknowledged by the community and being able to make a valuable contribution in their communities, enrich the participants' lives with joy and a positive feeling that boosts their sense of self and self-confidence.

These opportunities to play meaningful roles in their communities contributed to the participants being able to achieve a sense of well-being in the face of the lack of acknowledgment and validation they received from other professionals and administrators in the workplace.

4.4 Traditional cultural view of sexual relationships versus empowerment regarding assertiveness in relationships

> You know our culture, if you talk to other people about sex it is difficult, but we are starting to be aware that it is necessary to talk about HIV and sex, and to teach other people about things like that. You know we blacks, our mothers didn't talk to us. Now we realise many of us made mistakes because our mothers did not speak to us.

The traditional African sense of decency regarding talking about sexual matters can be stressful to counsellors, as it is expected of them to discuss

sexual issues in the course of doing HIV counselling. In many African families, sexuality and sex is not openly discussed, not even between mothers and daughters. The taboo of all discussions regarding sexual matters must necessarily be broken by the HIV counsellors. They need to courageously, but sensitively, venture on this terrain where generally only peers are comfortable talking to each other. One of the creative solutions was to form a discussion group for teenage girls in the community. The practical necessity of confronting the HIV pandemic on all fronts includes overstepping traditional taboos and boundaries. Zambian studies recommend that cultural barriers to openly discussing sexual matters existing in African cultures, should be explored and that the counsellors need more assistance and training in discussing issues around sexual behaviour with their clients (Baggaley, et al, 1994).

> My sister's son asks me (a woman) things he wants to know about HIV. He asks me how to use a condom, he would not have asked me that if I wasn't a HIV counsellor.

The importance of the above statement lies in the overcoming of cultural barriers which restrict talk about sexual matters to peers and to gender groups. It was repeatedly stated by participants that they were less shy talking about sexual matters to friends, relatives and people in the community than they were before they were involved with HIV counselling.

4.4.1 Traditional female gender roles versus emancipated female roles

> I am married in the Zulu tradition to a Zulu person. That Zulu person grew up in a big family with many mothers with one man. So that thing in Kwazulu- Natal is a priority to have many women. They think they are strong men if they have many partners. Now something has changed on my side, I feel to abstain.

Counsellors are informed and experienced regarding matters pertaining to HIV infection and therefore become more critical of traditional practices like polygamy, as well as the patriarchal view that women should submit to their husbands' needs and wishes. Not only do cultural and traditional customs in the context of HIV infection cause stress in the counselling of clients, but in some cases also in their personal lives.

> I am starting not to love my partner like I did before, because of what I am seeing. I am just getting scared daily and I am losing interest. I was just afraid to be involved with a male, because of ... it is like I know too much about it. Instead of approaching it, I decided just to be away from it that makes me to be alone.

The participants experience a negative effect on their sexual well-being in the sense that female participants tend to shy away from relationships, sexual or romantic. Four participants have not been in a relationship for as long as four years. The participants mentioned feelings of lack of trust in their partners, and even loss of interest in sex. This, in the long run, could have a limiting effect on their sexual well-being and development. Two participants who have been married for several years, both expressed losing interest in the sexual relationship with their husbands, and also mentioned increasing

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mistrust in their husbands' fidelity. In the research done in Zambia, the recommendation regarding this phenomenon is that female counsellors in particular, need support in dealing with their own sexual relationships (Baggaley et al., 1994).

However, at the same time the participants became empowered through the knowledge gained from their work and started asserting their rights regarding sexual matters. This is in line with psychological strengths involving courage, specifically emotional bravery, which allows people to stand up for what they believe in, despite opposition (Peterson & Seligman, 2004). On talking about relationships, a participant was adamant that she would not get married unless it is the right man, this notwithstanding pressure from her family to be married and start with a family.

The sense of empowerment they experienced had a definite influence on their sexual lives and relationships. Eight of the participants are female, and all of them made statements to the effect that they are enabled through their knowledge to negotiate safer sex with their partners. The empowerment of women is significant in our present struggle for gender equality in South Africa. This sense of empowerment manifests in the female participants insisting on the use of condoms, going with their partners for HIV testing, and most importantly, talking openly to their partners about the relationship and HIV in particular.

They have started to assert their right not to be in a sexual relationship should they so choose, or if they do go into a relationship, it should be according to their own needs and expectations. It is traditionally not common in the African community for women to assert their sexual rights in this way.

In the face of the awareness of the danger of contracting HIV, and the difficult personal choices regarding their own sexual behaviour and the ensuing negative effect, participants adamantly expressed the benefits they derived from being empowered regarding sexual matters. As a result of this, relationships are more open and egalitarian. Partners are, surprisingly, willing to discuss sexual health and responsible sexual behaviour. This constitutes a major change in relative status of the relationship partners. It is thus understandable that female participants experience feelings of empowerment and psychological well-being.

4.5 Participants are burdened, yet motivated

Participants expressed their concern about stressors specific to HIV counselling, which include the stigma associated with HIV, the trauma experienced by a client who tested HIV-positive, the attitude of clients concerning lifestyle changes and ethical demand for confidentiality. These stressors emotionally burden the participants and lead to emotional reactions that their training did not equip them to manage. Misplaced feelings of guilt are particularly evident; guilt at having to break the news of an HIV-positive result. Feeling culpable because they cannot do more for their clients, they cannot make the problem go away.

> I feel very much bad, because when this person looks at you, you feel so guilty, as if it was you who has infected him. So, it is heartbreaking on the counsellor.

These feelings of guilt could be influenced by the African sense of community, or "ubuntu" but can mainly be ascribed to the lack of training and mentoring or debriefing. Training should teach counsellors not to become involved with the counselees and to be caring and available for clients without becoming emotionally involved. As counsellors they should be taught not to take the burdens, emotional or otherwise, of their counselees upon themselves. These feelings of guilt would certainly contribute to the counsellors experiencing stress in the workplace,

> After forty-five minutes of speaking to the patient, the patient understood everything, when he left he asked 'what did you say I have AIDS? It showed the person didn't hear anything, but he said he understands. I always call the person for another appointment, to see her again. At times it is not that the person does not understand, they don't want to believe the results they got, and in few days it will sink in, and it is then you have time to talk and explain. [But many times] they, the clients, go back to their bad behaviour, sex without condoms. Why do they have more partners, why don't they stick to one partner? And I become scared, because we are losing the young generation. Sometimes I feel unhappy, I think maybe I can quit. But then, the people know me and the way I counsel them, it is important that I am here to counsel them.

The participants repeatedly expressed their frustration and distress with the unwillingness of clients to change to responsible sexual behaviour. Once again, the feeling of being intimately part of a community can contribute to

them experiencing extreme stress when witnessing clients and members of the community persisting in unsafe sexual practices.

The ethical imperative of confidentiality is a heavy burden and an additional source of stress as participants feel powerless in situations where HIV-positive clients refuse to inform their partners and to change their sexual behaviour. To a certain extent, this 'secrecy' is in opposition to the African attitude of being closely involved with each other. The concern about the impact of HIV, because of resistance to behaviour change, is also about their communities, and not just about their clients. Most participants expressed their concern about the future generation if sexual behaviour did not change.

However, this concern about the future generation is also a strength, motivating the participants to carry on with their work. The participants exhibited a strong future-orientation, which Peterson and Seligman (2004) classified under the strength of hope, being able to see a bigger picture than just their immediate realities. The strength *hope* consists of the constructs *optimism*, *future-mindedness* and *future orientation*. This strength can be described as a "cognitive, emotional and motivational stance toward the future" (Peterson & Seligman, 2004, p. 570). Hope allows the participants to be orientated towards a future outcome, and although usually in an optimistic sense, the future orientation can also be negative, though hopeful (Peterson & Seligman, 2004).

4.6 Participants have limited access to resources, yet they are in general empowered

Disadvantages stem from various systemic problems, like the shortage of acceptable office space for the participants to conduct their counselling, lack of a private quiet place for themselves in order to unwind and relax, both at work and at home. The participants clearly experience the lack of amenities as frustrating, painful and counter-productive (Rohleder & Swartz, 2005).

> If (only) we could have enough space for counselling ... If (only) the offices can be next to the people...For us as counsellors to reach these people we need transport to go out, to teach these people about health ... And some of them they do die, and there is nothing you can do. Nothing you can do. [But] counselling encouraged me to be powerful, to be strong.

Working under difficult physical circumstances is a reality for most counsellors, and participants mentioned their concern about these difficulties. I noticed that they often expressed these concerns more on behalf of their clients than on behalf of themselves. Many participants work in clinics which lack space, and the counsellors must quite often be satisfied to do counselling in the tearoom, or to share a room with nursing staff.

The need for taking the services closer to the people was expressed in regard to community members who live in poverty and do not have the means to travel to clinics. Participants' feelings of desperation in the face of the plight of their communities is evident, they are to an extent more concerned about

their clients than about themselves, which can be seen as human strength of citizenship. Citizenship includes attributes such as social responsibility, loyalty and loyalty to the larger group, and generativity (Peterson & Seligman, 2004). People with this strength will work for the common good of their communities, regardless of personal gain. In line with their commitment to community, such persons will often be involved with civic action and volunteer work. This commitment of the participants to the community, develops from a sense of citizenship.

The participants themselves are empowered with knowledge, about health in general, but also regarding communication skills, assertiveness, and self-knowledge. Participants who were shy and had difficulty in talking to strangers, have learned to reach out to others, to believe in themselves and became generally empowered. .

> Since I was a counsellor, I believe in myself. The counselling itself, you know, I use it
> to implement in my own lifestyle, and it was guidelines of how to live my life also
> counselling encouraged me to be powerful, to be strong.

The participants gained through the knowledge and skills they acquired as they expressed the feeling of being more equipped to handle life's problems than they had been before working as counsellors. The enhancing effect the counselling has on their lives, must be understood within the traditional African context of sense of community. They are now in the position to play a meaningful role in their communities. Volunteer work contributes to sustaining the well-being of those involved (Cheung & Kwan, 2006).

The participants' immediate families and friends are also empowered through their knowledge, directly through the fact that the counsellors share their knowledge with the important others in their lives, but also indirectly through the example they set.

> I am happy to be an HIV counsellor, because now I am talking about the things that I know. So, I am so happy about that, because even on my family, not on my clients only. I think I influenced them.

4.7 Despite all the difficulties, the participants express general life satisfaction.

> I am enjoying life. Although there are some obstacles, I am managing.

Despite all the problems the participants experienced in the workplace, like stressors of working in the field of HIV, organisational shortcomings and personal problems like insufficient and irregular payment of stipends, and the problems of their specific socio-economic environment, many participants testified to the fact that they were generally happy with their lives and experienced satisfaction with life. They held the opinion that they would prefer to carry on being HIV counsellors, despite the frustrations they experience. Louw, Van Ede and Louw (1998:530) define life satisfaction "as the emotional component of people's view of their own lives". It is based on their feelings about the past, present and future. Life satisfaction is closely linked to psychological well-being and can be viewed as a main indicator of psychological well-being (Mokgatlhe & Schoeman, 1998).

4.8 Concluding remarks

My point of departure was to investigate whether psychological strengths can act as protection against the adverse effects of stressors and even serve as motivators for further growth and personal development (Valle, Huebner & Suldo, 2006). The results suggest that this indeed is the case in the lives of the participants. They view their jobs and lives as meaningful, although they are confronted with significant difficulties in the work situation as well as in their personal lives.

The participants' positive view of their work is clear when considering that most of them have been in the positions for a few years - up to four years at the time the research was done- and expressed the wish to carry on doing counselling; they have the desire to qualify as trained counsellors.

Through my experience working with HIV counsellors, it became clear to me that the exposure to training courses and new ideas while doing volunteer counselling, equipped and motivated the counsellors to apply for other positions, some related to HIV counselling, some not related. One of the participants progressed to being employed by her NGO as an auxiliary social worker after completing the one-year certificate course, and at present she has enrolled to do the Social Work course at university level. Another participant has been employed by the Department of Local Government as a community development worker. Clearly, their psychological strengths that

empowered them to cope with stressors in handling the problems associated with their positions as volunteer counsellors, have also motivated them to pursue careers more beneficial to their positions in life, and with that enhancing their satisfaction with life. Participants who stay in their current positions, experience personal growth and meaning by escaping from their previous unemployment and or less desirable employment.

Chapter 5

Conclusions: the psychological well-being of HIV counsellors

5.1 Overview

Relatively little research could be found on the personal experiences of volunteer HIV counsellors, and the influence their work has on their well-being. This is a significant limitation in available research, as the volunteer counsellors play such an important role in the prevention of HIV infection, and the care of HIV-positive clients. Through this research, participants were given the opportunity to express their experiences as HIV counsellors and how their work influenced their quality of life, thereby creating a better understanding of their experiences. The value of this endeavour lies on various levels:

- Through a better understanding of the participants' experiences and the process of inductive interpretation, a description of their psychological well-being was created.

- The inconsistency between the stressful events of the participants' work lives, and their apparent ability to transform many negative experiences into opportunities for learning and growth, was highlighted.

- The psychological strengths that enable the counsellors to cope, and even thrive, in very difficult circumstances, were described.

- The volunteer counsellors' dreams of becoming better qualified and providing a professional service, were identified and voiced.

- In this process, limitations in the participants' training and work environments became clear.

5.2 Limitations of the study

The research adds to the knowledge regarding the counsellors' experiences and the work they do. It put into words their experiences and needs. Yet, there are some limitations.

- A limitation of qualitative research is that findings cannot be generalised. These research findings paint a picture of the lives of HIV counsellors in a specific context at a specific time.

- Interviews were conducted in English, a second (or even third) language for all the participants. Most of the participants were not able to fluently elaborate on their views and experiences, due to limited vocabulary. This limitation restricted the depth of the interview data. These data were supplemented by other sources of data.

- Cultural difference between the participant's background and that of the researcher might also have contributed to imperfect understanding. To limit the influence of this factor, participants were consulted regarding the interpretation of the interviews to ensure the trustworthiness of the interpretations.

5.3 Conclusions

The following conclusions were deducted from the study:

- The participants worked under difficult circumstances due to systemic problems at the workplace, like shortage of space, lack of privacy, low and infrequent payment, and the need to be permanently employed.

- The participants experienced stress intrinsic to HIV counselling, for example, dealing with the trauma of their clients upon receiving an HIV-positive test result, unwillingness of clients to make lifestyle changes, confidentiality and the implications thereof, and feelings of guilt when giving a positive result and being unable to do more for the clients.

- Stress is also caused by their concern for their clients' and communities' well-being, and reached even further to concern for the future generation in view of the consequences of HIV.

- The lack of training, mentoring and debriefing ill-equipped the participants to deal with the abovementioned stressors.

- The participants expressed a need to be recognised by the authorities, and to be able to be involved with decision-making, or at least to make a contribution to the decision-making process.

- Because dealing with HIV cannot be separated from talking about sexual relationships, the participants experienced stress regarding this in relation to the traditional African sense of decency.

- Participants also experienced stress in their personal sexual relationships due to their increased awareness of infidelity and the results of HIV infection.

- Stressors in their personal lives: unfavourable socio-economic circumstances and encountering the impact of HIV in their personal relationships add to this burden of stress the participants carried.

Despite the detrimental influences of their work on their well-being, the participants experience life satisfaction and psychological well-being through character strengths they possess:

- The participants succeeded in developing their own ways of stress relief, especially through the practising of their spiritual beliefs, participating in community activities, and engaging in meaningful relationships with significant others.

- The participants all testify to experiencing personal growth and empowerment in general, but especially in the field of health and sexuality. The female participants were increasingly able to negotiate safer sex.

- The lives of the participants are enriched through, amongst others, the regard they receive from their communities, and being in a position to give information and advice that they gained from the training and exposure to information.

- The participants experience feelings of self-worth in that they are able to contribute to their communities, thereby adding meaning to their own existence, which enhances their psychological well-being.

5.4 Recommendations for further study

The dire need for the adequate training and mentoring of volunteer HIV counsellors has been clearly identified. It has also become clear that the character strengths of the counsellors could function as a foundation for their growth and psychological well-being. Further research could contribute to the development of a comprehensive training and mentoring programme and its evaluation in terms of enhanced service delivery, but also regarding the personal development of the volunteers who are trained to counsel.

5.5. Practical recommendations

The initial and continuous training and work circumstances of the volunteer HIV counsellors need urgent attention from all stakeholders:

- Concerned government departments are the custodians of the volunteer HIV counsellor programmes intended to address the HIV pandemic through the VCT Programme. They need to develop and adequately finance a comprehensive training, mentoring and monitoring system to create a healthy structure to enable counsellors to deliver the service without compromising their own mental and physical well-being.

- Non-governmental organisations need to view this service as a priority and second motivated, experienced and effective mentors.

- The multi-disciplinary teams at primary healthcare clinics need to accept and respect the contribution of volunteer HIV counsellors, and include them in the day-to-day activities of the clinics.

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ANNEXURE1

Summary of participants in research study

PARTICIPANT *Pseudonym	AGE	GENDER	NO OF YEARS CNSL	RELATIONSHIP HISTORY	RELIGION	NO OF CHILDREN	PREVIOUS EXPERIENCE	GENERAL
1. Nosipho*	44	Female	3 months	Married for 20 years	Methodist Church	3 sons: 25 -12	Relief worker	
2. Maserame*	43	Female	7 years	Widow for 7 years. No relationship now. Was married for 20 years.	Religious, attends church	1 daughter, 21 years	Admin clerk; was unemployed for 1 year.	Not doing counselling for 1 year now
3. Thabile*	30	Female	2 years	Single, 6 years in present relationship	Religious, goes to church	1 son,13	Studied Fashion Design	
4. Susan*	49	Female	4 years	Married	Very religious	3 children, 30 - 16	Worked in bank. Stayed @ home: spaza shop	
5. Phumi*	27	Female	4 years	Single, not in relationship now	Religious, father is a priest	Nil	HIV campaign volunteer	
6. Elisabeth*	38	Female	2 years	Single, no relationship for 4 years	Religious	1 son, 7	Unemployed	
7. Nomsa*	31	Female	5 years	Single presently in relationship	Religious, strengthened by counselling	2 sons, 10 & 6	Domestic worker	
8. Thandi*	27	Female	4 years	Single, no relationship for 2,5 years	Religious, no change	Nil	Volunteer for HIV campaigns	
9. Mandla*	30	Male	3 years	Not married, in long-term relationship	Rasta	1 son, baby	Trained/worked as chef	Not working as counsellor for 1 year

Annexure 2

LETTER OF CONSENT

I, Louise van Aswegen, am doing the MA Degree in Psychology at the North-West University, Vaal Campus. I am doing a qualitative research study, with the title "The affect the experiences of HIV Counsellors have on their own well-being. A case study." For the purpose of the study I need to do interviews with at least 8 HIV Counsellors.

I will at all times respect the dignity and personal experiences of all participants. All information will be regarded as confidential, and when referrals are made to personal opinions of participants, it will be done under a pseudonym. I will be open and honest at all times about the information and methods I am going to use. The participants will be involved with the whole process, and will be asked for final insets before the article is published.

If you are willing to participate in this study, please sign this letter to give your written consent to the above.

Thank you for your willingness, and trust in me, to participate in this study.

Louise van Aswegen

Participant   Date: