Course Name	: HIV/AIDs Management & Counseling
Course Code	: APBPH 3104
Course level	: Level 5
Course Credit	: 4 CU
Contact Hours	: 60 Hrs

Course Description

The Course focuses on the transmission & treatment of HIV/AIDs, factors that play in the increase of HIV transmission. It details the qualities of an effective counselor, basic communication skills in HIV counseling, guidelines in pre-test counseling, guidelines for counseling to an HIV positive client, impact of HIV infection on affected significant others, helping the infected person and affected significant others, Bereavement Counseling, Counseling inform of Suicide Intervention, Stress, Anxiety and tension Management, and Counseling Psychology.

Course Objectives

- To introduce students to counseling skills and how to handle people living with HIV.
- To help students acquire a wide knowledge of principles relevant in the field of HIV management and counseling such as acceptance, individualization to mention but a few.
- To enable students appreciate that people living with HIV are not victims of circumstance but they need their psychological, emotional and financial support to view their life as worth living.

Course content

Introduction to HIV/AIDs Background

- Presentation of HIV/AIDs
- HIV/AIDs Transmission
- HIV/AIDS treatment
- Research to improve current treatment
- Prevention and control measures
- Factors that play a role in the increase of HIV transmission

Qualities of an Effective Counselor

- Respect
- Genuineness and congruence
- Empowerment and self responsibility
- Confidentiality

Basic Communication skills in HIV counseling

- Attending
- Listening

- Basic empathy
- Probing or questioning
- Summarizing
- Integrating communication skills

Guidelines in Pre-test Counseling

- Explore reasons for testing
- Assessment of risk
- Beliefs and knowledge about HIV infection and safer sex
- Information about the test
- The implications of an HIV test result
- Anticipate the results
- Confidentiality of test results
- Informed consent
- Information about giving the results and ongoing support
- The waiting period

Guidelines for counseling to an HIV positive Client

- Sharing the news with the client
- Client reaction to a positive HIV test result
- Responding to client needs
- Crisis intervention
- Follow-up visits
- Support systems
- Advice about health and sexuality
- Medical checks-ups

Impact of HIV infection on affected significant others

Helping the infected person and affected significant others

- Support and empowerment
- Peer support (buddy system)

Bereavement Counseling

- Meaning of Bereavement Counseling
- Kubler-Ross's stages of dying
- The four tasks of mourning
- Useful techniques in bereavement counseling

Counseling inform of Suicide Intervention

- Meaning of Suicide Intervention/suicide intervention
- First Aid for Suicide ideation
- Suicide prevention
- Historical foundation of suicide prevention

Stress, Anxiety and tension Management

- Differentiation between the concepts
- Symptoms of anxiety, stress or tension

- How to cope with stress
- Models of Stress Management
- Techniques of stress Management

Counseling Psychology

- Meaning of Counseling Psychology
- Counseling process and outcome
- Counseling relationship

Psychotherapy

- Meaning of psychotherapy
- Forms of psychotherapy
- Psychotherapy systems
- General concerns
- Specific schools and approaches in psychotherapy

Mode of delivery Face to face lectures
Assessment
Course work 40%
Exams 60%
Total Mark 100%

HIV/AIDS MANAGEMENT AND COUNSELING

HIV/AIDS background

HIV is an infectious human retrovirus, a virus that overtakes the biosynthesis of living cells to duplicate itself. In other words, HIV invades a normal cell and uses the cell's biomechanisms to produce new HIV cells.

Human immunodeficiency virus first was seen in the early 1980's in the United States when young homosexual men especially were found with unusual infections. The virus was identified in 1983 and the Food and Drug Administration (FDA) approved an HIV diagnostic criteria. According to the Centers for Disease Control and Prevention (CDC), in the United States an estimated 650,000 - 900,000 individuals were living with HIV/AIDS in June of year 2000. Prior to that, another 435,000 persons had died from AIDS.

Although these numbers are large, the number of persons affected by the virus globally is much greater. In 1999, the World Health Organisation (WHO) estimated that 33.6 million persons were living with HIV/AIDS worldwide, and that 2.6 million deaths had occurred, many of these in sub-Saharan Africa.

Sub-Saharan Africa accounts for more than 60% of all people living with HIV,

yet the region has just over 10% of the worlds population. In 2004, an estimated 139.4 million people were living with HIV globally. In the same year, an estimated 4.9 million people globally became newly infected while 3.1 million people died of AIDS.

AIDS occurs during the later stages of HIV infection. As the virus progressively destroys the immune system, a variety of infections and concerns can develop. Originally, it was believed that all HIV infections would ultimately develop AIDS, but today with a lot of powerful antiretroviral drugs, this may not always be the case. AIDS signs and symptoms are cured through these antiretroviral drugs. In addition, some individuals seem to maintain a healthy immune system, according to the standards of living despite HIV infection. These individuals are called long-term non-progressor's.

In 1993, CDC revised its classification system for AIDS. All HIV positive persons with a T-cell count below 200/mm3 are now considered to have a diagnosis of AIDS. In addition, persons with HIV and certain opportunistic infections or concerns also meet the case definition for AIDS.

- Presentation and transmission of HIV/AIDS
- HIV/AIDS treatment
- Prevention and control measure
- Factors that play a role in the increase of HIV transmission
- References

Presentation of the disease

AIDS/HIV is a condition that is characterised by many different illnesses.

- A person who is only infected with HIV can look healthy over time. But as the virus destroys his immunity, he or she develops AIDS. The mixture of signs and symptoms of the various diseases which take advantage of the body's weakened defences (immune suppression) to attack is growing.
- A person can live with HIV for a long time (up to 15 years) before developing and showing signs of AIDS.
- A person with early HIV may not be recognized unless he or she undergoes an HIV test.

HIV/AIDS transmission

HIV is transmitted through:

1. Sexual intercourse (vaginal or anal) with an infected partner, especially in the presence of a concurrent ulcerative or non-ulcerative sexually transmitted infection (STI)
2. Transfusion of interested blood or blood products.
3. Contaminated needles (injecting drug use, needle stick injuries and injections)
4. Mother-to-child transmission during pregnancy, labour and delivery or through breast feeding.

HIV/AIDS treatment

HIV/AIDS ***has no cure!*** When AIDS first surfaced in the United States as an epidemic disease, no drugs were available to combat the underlying immune deficiency, and few treatments existed for the opportunistic infections that result.

Although there is currently no treatment available that can cure the people with HIV/AIDS, a number of therapies have been developed to help them stay healthier and live longer and this has been for the period of 10 years for both HIV infections and its associated infections.

- Some medications target HIV itself, to reduce the virus's assault on the immune system, or even to prevent the virus from attacking the immune system.
- Other treatments are used to treat or prevent specific infections that threaten the health of the people with HIV damaged immune system.

However, the course of antiretroviral drugs (ARVs) treatment administered immediately after exposure, referred to as post-exposure prophylaxis (PEP), is believed to reduce the risk of infection if any, when began as quickly as possible.

Currently treatment for HIV infections consists of highly active antiretroviral therapy (HAART). This has been highly beneficial to many HIV-infected individuals since its introduction in 1996, when the protease inhibitor-based HAART initially become available.

The HAART options are combinations or cocktail consisting of at least 3 drugs belonging to 2 types.

- Nucleoside analogue reverse transcriptase inhibitors (NARTIs) or NRTIs
- Protease inhibitor or non-nucleoside reverse transcriptase inhibitor (NNRTIs)
- Entry inhibitors

These provide treatment options for patients who are infected with viruses already resistant to common therapies. Nonetheless, they are not widely available and not typically accessible in resource limited settings. ARVs are expensive too, and many infected individuals are poor not to afford prices to undergo medications and treatment for HIV/AIDS. They are mostly recommended for children, not adults because AIDS progression in children is more rapid and less predictable than in adults.

NOTE: Thanks to these treatments, many HIV-infected individuals have experienced remarkable improvements in their general health and quality of life, which has led to a large reduction in HIV associated morbidity and mortality in the developed world.

One study suggests the average life expectancy of an HIV-infected individual is 3 years from the time of infection, if treatment is started when the CD4 count is 350/ul.

In the absence of HAART, the life expectancy of an HIV-infected individual is at the median of between 9-10 years and median survival time is only 9.2 months after developing AIDS in the developing world.

The time for starting HIV treatment is still debated, others say that treatment be started before the patients CD4 count for or falls below 200/mm3 and most say treatment start once the CD4 accounts are not available, patients with WHO stages III or 1V should start the treatment .

Research to improve current treatment includes:

- Decreasing side effects of drugs.
- simplifying drug regimes to improve adherence
- determining the best sequence of regimes to manage drug resistance
- Vaccination is also being considered to be able to halt the pandemic. This is because a vaccine would cost less, thus being affordable for low developing countries and it would not require daily treatment. However after 20 years of research it has been shown that HIV-1 remains a difficult target for a vaccine.

Prevention and control measures

A lot of measures can be taken to reduce the different forms of HIV transmission:

- Awareness and life skills education, especially for young people, to ensure that everybody is well informed of what does and does not

constitute a mode of transmission, of how to acquire free condoms and medical attention if necessary, and of basic hygiene.

- Promotion of the use of condoms, ensuring that good quality condoms are freely available to those who need them, together with culturally sensitive instructions.
- Sexually transmitted infections (STIs) control. This should be done by health workers, who use syndromic STI management approaches (as laboratory services for confirmation are unlikely to be available in emergencies), with partner notifications and promotion of safer sex.
- Reduction of mother-to-child transmission of HIV by:
    - Avoiding unintended pregnancies among HIV "infected women and promoting family planning methods, particularly in women who are HIV infected.
    - Preventing the transmission of HIV from pregnant women to their infants by using an antroviral prophylaxis regimen.
    - Avoiding unnecessary invasive obstetrical procedures, such as artificial rupture of membranes or episiotomy.
    - Modifying infant feeding. Feeding can be given with a cup when acceptable and safe, otherwise exclusive breast feeding for the first months of life is recommended.
- Blood safety
    - HIV testing of all transfused blood.
    - Avoiding of non essential blood transfusion.
    - Recruitment of a safer blood donor pool.
- Universal precautions. This means building up the personal understanding of the disease and its causes and promoting the following procedures:
    - Washing hands thoroughly with soap and water, especially after contact with blood fluids or wounds.
    - Using protective gloves and clothing when there is a risk of contact with blood or other potentially infected body fluids.
    - Safe handling and disposing of waste materials, needles and other sharp objects, properly cleaning and disinfecting medical instruments between patients.
- Physical protection, i.e. protecting the most vulnerable, especially women and their children from violence and abuse is not the only important principle of human rights but also essential for reducing the risk of HIV infections.
- Protecting health care workers
    - In order to reduce the nosocomial transmissions, health workers should strictly adhere to the universal precautions with all patients and laboratory samples, whether or not known to be infected with HIV.
    - Health workers should access to voluntary counselling, testing and care, often health workers deployed in complex emergencies

experience significant occupational stress, and those tested as part of occupational exposures will require additional support.
    - Post-exposure prophylaxis (PEP) kits must be made available to protect workers who have been sexually assaulted. PEP kits are distributed through the United Nations dispensary system.
- Counselling and voluntary testing programmes should be supported by the governments and individual participation should be promoted
    - It is important that the available resources for HIV testing should be devoted to ensure a safe blood supply for transfusions.
    - Establishments of voluntary testing and counselling services to help individuals make informed decisions on HIV testing should be considered when relative stability is restored.
    - As refugees are often tested before resettlement in their countries, it is critical that they receive counselling on the legal and social implications of the test.
    - Post-test counselling is essential for both sero-negative and sero-positive results. Refugees and conflict survivors who are already traumatized will require additional psychological support net works of displaced persons are disrupted, and suicide risk assessment forms an important part of post-testing counselling in a refugee or conflict context.
    - Testing of orphaned minors should be done with the consent of the official guardians, only where there is an immediate health concern or benefit to the child. There should be no mandatory screening before admittance to substitute care.
- Vaccination
    - Asymptomatic HIV-infected children should be immunized with EPI vaccines.
    - Asymptomatic HIV-infected children should not receive BCG or yellow fever vaccines.

Factors that play a role in the increase of HIV transmission

1. ***Population movements***

Population movements often lead to a break down in family and social ties and erodes traditional values and coping strategies. This can result in high risk sexual behavior which increases the risks of the spread of HIV. In high incidence regions, refugees from areas where HIV is rampant are living together in a close area. Moreover, there is usually little prior knowledge of HIV risks and prevention.

2. ***Overcrowding***

Groups with differing levels of HIV awareness and differing rates of infection are often placed together in temporary locations such as refugee's potential for sexual contact.

3. ***Poor access to health services***

Without medical services for outbreaks of sexual transmitted infections (STIs), the spread of the disease is huge. If left untreated in either partner, the risk of acquiring HIV greatly increases. Important materials for HIV prevention, in particular condoms, are likely to be lacking in emergency situations.

*4. **Sexual violence***
Especially refugees and internally displaced people are often physically, socially powerless. Women and children are at a particular risk of social co-coercion, abuse or rape. Sexual violence carries a higher risk of infections because the person violated can not protect herself from unsafe sex, and if this is the cause the virus can be transmitted more easily if the body tissues are torn during the violent sex.

*5. **Sex workers***
Exchange of sexual favours for basic needs, such as money, shelter, food, clothes, and others, is common in or around camps, towns and inevitably involves both the refugees and the host community. Both sex workers and clients are at the risk of HIV infection if unprotected sex is practised.

6. **Injected drug use**
In the critical conditions of an emergency, it is highly likely that drug injectors will be sharing needles, a practice that carries a high risk of HIV infection if one the people sharing is infected.

7. **Unsafe blood transfusions**
Transfusion with a HIV infected person's blood is highly efficient means of transmitting the virus. In emergency situations, when regular transfusion services have been broken down, it is particularly difficult to ensure blood safety.

Basic HIV counseling principles

The advent of HIV/Aids in the world has forced all of us to accept a paradigm shift from curing towards caring. Because we have no cure for HIV/Aids, we have to focus our interventions on caring for the physical as well as the psychological welfare of the HIV? positive individual and his or her significant others.

The HIV positive individual needs to find ways to live a psychologically healthy life after diagnosis. The need for counsellors to assist HIV positive individuals and their loved ones are so great, that we need to equip everyone in the helping professions with the necessary skills to be effective HIV/Aids counsellors.

“The single most important requirement to be an HIV/Aids counsellor, is to have compassion for another person's struggle to live beyond the confines of a

disease, and the willingness and commitment to walk the walk with this person and his or her significant others." (Johnson, in Van Dyk, 2001.)

The aims of counselling or helping a client must always be based on the needs of the client. The purpose of counselling is twofold: (1) to help clients manage their problems more effectively and develop unused or underused opportunities to cope more fully, and (2) to help and empower clients to become more effective self helpers in the future (Egan, 1998). Helping is about constructive change and making a substantive difference to the life of the client. But only the client can make that difference: the counsellor is merely an instrument to facilitate that process of change.

Qualities of an effective HIV counselor

To be an effective HIV/Aids counselor, you need the following qualities or values:

1. Respect

The belief that every person is a worthy being who is competent to decide what he or she really wants, has the potential for growth, and has the abilities to achieve what he or she really wants from life.

A counsellor can show his or her respect to clients in the following ways:

- Accept the client by showing unconditional positive regard. This means that you as counsellor accept the client as he or she is, irrespective of the client's values or behaviour and of whether you as counsellor approve of those values and behaviour or not. A judgemental counsellor who condemns clients or who makes clients feel that their sexual behaviour is offensive to the counsellor, will not be able to facilitate healing, and will only do harm.
- Respect the client's rights. Individuals have a right to be who they are, a right to their own feelings, beliefs, opinions and choices.
- Respect the uniqueness of each client.
- Refrain from judgement. Counsellors are there to help their clients, not to judge or to blame them. Since HIV?infected individuals often already feel that they are "guilty" or "bad" before counselling even starts, only non?judgmental attitudes on the part of the counsellor will facilitate understanding and growth.
- Remain serene and imperturbable and never react with embarrassment, shock or disapproval when people discuss painful situations or their sexual practices with you.

2. Genuineness and congruence

Genuineness refers to being honest and transparent in the counselling

relationship. A genuine or congruent counsellor demonstrates the following values or behaviour:

- Be yourself. Be real and sincere.
- Be honest with yourself and your clients.
- Don't be patronising or condescending.
- Keep the client's agenda in focus. Don't pursue your own agenda or inflict yourself on others.
- Don't be defensive. Know your own strengths and weaknesses.
- Strive towards achieving openness and self?acceptance because these qualities will enable you to accept people whose behaviour conflicts with your own personal values. Remember that it is impossible to hide negative feelings from clients. No matter how hard you try to conceal them, clients will sense your incongruence.
- When clients react negatively to you or criticise you, examine the behaviour that might have caused the clients to think negatively.

3. Empowerment and self responsibility
One of the values underlying counselling should be the desire to empower clients to take responsibility for themselves and to identify, develop and use resources that will make them more effective agents of change in the counselling sessions as well as in their everyday lives. The empowerment of clients should be based on the following values:

- Accept the principle that the client knows himself or herself better than anyone else, and that he or she is therefore in the best position to explore, expose and understand the self.
- Believe in the clients' ability to change if they choose to do so. Trust clients' ability to manage their lives more effectively. It is the task of the counsellor to help clients to identify and use their resources.
- Refrain from "rescuing" the client. This means that you should not take responsibility for another person's feelings, choices or actions. Allow the client to take responsibility for him or herself.
- Help clients to see counselling sessions as work sessions. Only the client can make change happen. The counsellor can merely make suggestions about how the client might change.
- Help clients to become better problem solvers in their daily lives.

4. Confidentiality
Confidentiality in the counselling context is non?negotiable. A counsellor may under no circumstances disclose the HIV status or any other information to anybody without the express permission of the client. Confidentiality is an expression of the counsellor's respect for the client.

Basic communication skills in HIV Counseling

Since counselling is a conversation or dialogue between the counsellor and client, the counsellor needs certain communication skills in order to facilitate change.

The counsellor needs the following basic communication skills to do effective counselling:

1. Attending

Attending refers to the ways in which counsellors can be "with" their clients, both physically and psychologically. Effective attending tells clients that you are with them and that they can share their world with you. Effective attending also puts you in a position to listen carefully to what your clients are saying. The acronym **SOLER** can be used to help you to show your inner attitudes and values of respect and genuineness towards a client (Egan.)

S: Squarely face your client. Adopt a bodily posture that indicates involvement with your client. (A more angled position may be preferable for some clients - as long as you pay attention to the client.) A desk between you and your client may, for instance, create a psychological barrier between you.

O: Open posture. Ask yourself to what degree your posture communicates openness and availability to the client. Crossed legs and crossed arms may be interpreted as diminished involvement with the client or even unavailability or remoteness, while an open posture can be a sign that you are open to the client and to what he or she has to say.

L: Lean toward the client (when appropriate) to show your involvement and interest. To lean back from your client may convey the opposite message.

E: Eye contact with a client conveys the message that you are interested in what the client has to say. If you catch yourself looking away frequently, ask yourself why you are reluctant to get involved with this person or why you feel so uncomfortable in his or her presence. Be aware of the fact that direct eye contact is not regarded as acceptable in all cultures.

R: Try to be relaxed or natural with the client. Don't fidget nervously or engage in distracting facial expressions. The client may begin to wonder what it is in himself or herself that makes you so nervous! Being relaxed means that you are comfortable with using your body as a vehicle of personal contact and expression and for putting the client at ease.

Effective attending puts counsellors in a position to listen carefully to what their clients are saying or not saying.

2. Listening
Listening refers to the ability of counsellors to capture and understand the messages clients communicate as they tell their stories, whether those messages are transmitted verbally or nonverbally.

Active listening involves the following four skills:

- Listening to and understanding the client's verbal messages. When a client tells you his or her story, it usually comprises a mixture of experiences (what happened to him or her), behaviours (what the client did or failed to do), and affect (the feelings or emotions associated with the experiences and behaviour). The counsellor has to listen to the mix of experiences, behaviour and feelings the client uses to describe his or her problem situation. Also “hear” what the client is not saying.
- Listening to and interpreting the client's nonverbal messages. Counsellors should learn how to listen to and read nonverbal messages such as bodily behaviour (posture, body movement and gestures), facial expressions (smiles, frowns, raised eyebrows, twisted lips), voice?related behaviour (tone, pitch, voice level, intensity, inflection, spacing of words, emphases, pauses, silences and fluency), observable physiological responses (quickened breathing, a temporary rash, blushing, paleness, pupil dilation), general appearance (grooming and dress), and physical appearance (fitness, height, weight, complexion). Counsellors need to learn how to “read” these messages without distorting or over?interpreting them.
- Listening to and understanding the client in context. The counsellor should listen to the whole person in the context of his or her social settings.
- Listening with empathy. Empathic listening involves attending, observing and listening (“being with”) in such a way that the counsellor develops an understanding of the client and his or her world. The counsellor should put his or her own concerns aside to be fully “with” their clients.

Active listening is unfortunately not an easy skill to acquire. Counsellors should be aware of the following hindrances to effective listening (Egan, 1998):

- Inadequate listening: It is easy to be distracted from what other people are saying if one allows oneself to get lost in one's own thoughts or if one begins to think what one intends to say in reply. Counsellors are also often distracted because they have problems of their own, feel ill, or because they become distracted by social and cultural differences between themselves and their clients. All these factors make it difficult to listen to and understand their clients.
- Evaluative listening: Most people listen evaluatively to others. This means that they are judging and labelling what the other person is

saying as either right/wrong, good/bad, acceptable/unacceptable, relevant/irrelevant etc. They then tend to respond evaluatively as well.
- Filtered listening: We tend to listen to ourselves, other people and the world around us through biased (often prejudiced) filters. Filtered listening distorts our understanding of our clients.
- Labels as filters: Diagnostic labels can prevent you from really listening to your client. If you see a client as “that women with Aids”, your ability to listen empathetically to her problems will be severely distorted and diminished.
- Fact?centred rather than person?centred listening: Asking only informational or factual questions won't solve the client's problems. Listen to the client's whole context and focus on themes and core messages.
- Rehearsing: If you mentally rehearse your answers, you are also not listening attentively. Counsellors who listen carefully to the themes and core messages in a client's story always know how to respond. The response may not be a fluent, eloquent or “practised” one, but it will at least be sincere and appropriate.
- Sympathetic listening: Although sympathy has it's place in human transactions, the “use” of sympathy is limited in the helping relationship because it can distort the counsellor's listening to the client's story. To sympathise with someone is to become that person's “accomplice”. Sympathy conveys pity and even complicity, and pity for the client can diminish the extent to which you can help the client.

3. Basic empathy

- Basic empathy involves listening to clients, understanding them and their concerns as best as we can, and communicating this understanding to them in such a way that they might understand themselves more fully and act on their understanding (Egan, 1998).
- To listen with empathy means that the counsellor must temporarily forget about his or her own frame of reference and try to see the client's world and the way the client sees him or herself as though he or she were seeing it through the eyes of the client.
- Empathy is thus the ability to recognise and acknowledge the feelings of another person without experiencing those same emotions. It is an attempt to understand the world of the client by temporarily “stepping into his or her shoes”.
- This understanding of the client's world must then be shared with the client in either a verbal or non-verbal way.

Some of the stumbling blocks to effective empathy are the following:

- Avoid distracting questions. Counsellors often ask questions to get more information from the client in order to pursue their own agendas. They

do this at the expense of the client, i.e. they ignore the feelings that the client expressed about his or her experiences.
- Avoid using clichés. Clichés are hollow, and they communicate the message to the client that his or her problems are not serious. Avoid saying: “I know how you feel” because you don't.
- Empathy is not interpreting. The counsellor should respond to the client's feelings and should not distort the content of what the client is telling the counsellor.
- Although giving advice has its place in counselling, it should be used sparingly to honour the value of self?responsibility.
- To merely repeat what the client has said is not empathy but parroting. Counsellors who “parrot” what the client said, do not understand the client, are not “with” the client, and show no respect for the client. Empathy should always add something to the conversation.
- Empathy is not the same as sympathy. To sympathise with a client is to show pity, condolence and compassion - all well?intentioned traits but not very helpful in counselling.
- Avoid confrontation and arguments with the client.

4. Probing or questioning

Probing involves statements and questions from the counsellor that enable clients to explore more fully any relevant issue of their lives. Probes can take the form of statements, questions, requests, single word or phrases and non-verbal prompts.

Probes or questions serve the following purposes:

- to encourage non-assertive or reluctant clients to tell their stories
- to help clients to remain focussed on relevant and important issues
- to help clients to identify experiences, behaviours and feelings that give a fuller picture to their story, in other words, to fill in missing pieces of the picture
- to help clients to move forward in the helping process
- to help clients understand themselves and their problem situations more fully

Keep the following in mind when you use probes or questions:

- Use questions with caution.
- Don't ask too many questions. They make clients feel “grilled”, and they often serve as fillers when counsellors don't know what else to do.
- Don't ask a question if you don't really want to know the answer!
- If you ask two questions in a row, it is probably one question too much.
- Although close-ended questions have there place, avoid asking too many close-ended questions that begin with “does”, “did”, or “is”.

- Ask open-ended questions - that is, questions that require more than a simple yes or no answer. Start sentences with: “how”, “tell me about”, or “what”. Open-ended questions are non-threatening and they encourage description.

5. Summarising
It is sometimes useful for the counsellor to summarise what was said in a session so as to provide a focus to what was previously discussed, and so as to challenge the client to move forward. Summaries are particularly helpful under the following circumstances:

- At the beginning of a new session. A summary of this point can give direction to clients who do not know where to start; it can prevent clients from merely repeating what they have already said, and it can pressure a client to move forwards.
- When a session seems to be going nowhere. In such circumstances, a summary may help to focus the client.
- When a client gets stuck. In such a situation, a summary may help to move the client forward so that he or she can investigate other parts of his or her story.

6. Integrating communication skills
Communication skills should be integrated in a natural way in the counselling process. Skilled counsellors continually attend and listen, and use a mix of empathy and probes to help the client to come to grips with their problems. Which communication skills will be used and how they will be used depends on the client, the needs of the client and the problem situation.

The eight commandments of emotional support

Pierre Brouard's eight commandments of emotional support can be applied by HIV/Aids counsellors.

1. Be non-judgemental
2. Be empathetic
3. Don’t give advice
4. Don’t ask why
5. Don’t take responsibility for the other person’s problems
6. Don’t interpret
7. Stick with the here and now
8. Deal with feelings first

Pre- and post- HIV test counseling

The HIV test is different from all other tests. It has phenomenal emotional, psychological, practical and social implications for the client.

- The HIV test is different from all other tests.
- It has phenomenal emotional, psychological, practical and social implications for the client.
- HIV testing should therefore never be done without thorough pre-test counseling.
- Pre-test counselling that is done in a proper and comprehensive way prepares the client and counsellor for more effective post-test counselling.
- Because clients are often too relieved or shocked to take much information in during post-test counselling, the health care professional should make use of the educational opportunities offered by pre-test counselling.
- Clients: although it may be difficult for you to go for pre-HIV test counselling, the psychological effects of being prepared by a professional for HIV testing far outweigh any possible "benefits" of privacy. Health care professionals are trained to do pre- and post-test counselling in a professional way and to keep all information confidential. It is also your right as client to stay anonymous or to use a pseudo (or false) name when you go for testing.

According to the National Policy on Testing for HIV (published in August, 2000) nobody may be tested for HIV without their informed consent, and without proper pre- HIV test counselling.

Pre-HIV test counseling

The purpose of pre-test counselling is to provide you with information on the technical aspects of testing and the possible personal, medical, social, psychological, legal and ethical implications of being diagnosed as either HIV positive or HIV negative.

The purpose of pre-test counselling is further to find out why you want to be tested, the nature and extent of your previous and present high-risk behaviour, and the steps that need to be taken to prevent you from becoming infected or from transmitting HIV infection.

The counselor will usually follow the following guidelines in pre-test counseling:

1. Reasons for testing

The counselor will explore the reasons why you want to be tested:

Is it for insurance purposes, because of anxiety about lifestyle, or because you have been forced by somebody else to take the test? What particular behavior or symptoms are causing concern to you? Have you been tested before, and, if so, when? For what reason? And with what result?

These questions provide the counselor with an opportunity to ascertain your perceptions of your own high-risk behavior, and with allows you to assess whether you intend to be tested and whether your fears are realistic or if you are unnecessarily concerned. The following are some of the reasons that clients who want to be tested often give:

- Their partner has requested it.
- They want to determine their HIV status before starting a new relationship.
- They want to be tested prior to being married.
- They feel guilty and concerned about having multiple sex partners.
- They have had recent sexual encounters in which they did not use condoms.
- They are manifesting symptoms that are giving them cause for concern.
- They are been referred by a STI or TB clinic because the client has tuberculosis or a sexually transmitted infection.
- They have come to re-confirm a positive HIV test.
- Their current partner is HIV positive, or they were once involved with a partner who was HIV positive.
- They plan to become pregnant and want to check their HIV status before they do so.
- They have been raped or assaulted.
- They need to be tested after an occupational exposure (e.g. a needlestick).
- There are simply curious.

The reason why a client wants to be tested is important because it sets the scene for the rest of the pre-test counselling session.

2. Assessment of risk

The counsellor will assess the likelihood of whether you have been exposed to HIV by considering how much and how frequently you have been exposed to the following risk factors and lifestyle indicators:

- What is your sexual risk history in terms of frequency and type of sexual behaviour? Have you been involved in high-risk sexual practices such as vaginal or anal intercourse with more than one sex partner without the use of condoms? In the case of anal sex, was it anal-receptive or anal-insertive sex? Did you have sex with a sex worker (or prostitute) without a condom? Or is your sex partner HIV positive?
- Are there any other risks involved? Are you an intravenous drug user, a prisoner who is exposed to rape or unprotected sex in prison, a migrant worker, a refugee or a sex worker? Have your been raped or coerced to have sex with another person? Do you have another sexually transmitted infection or tuberculosis?

- Did you receive a blood transfusion or body products in a developing country where testing blood for HIV is not standard practice? Note: All blood supplies in South Africa are tested for HIV, and are very safe.
- Have you been exposed to possibly non-sterile invasive procedures such as tattooing, piercing or traditional invasive procedures such as male or female circumcision and scarification for the application of medicines?
- Have you been exposed to HIV-infected blood in the work situation? (E.g. injuries with large volumes of blood involved, or needlestick injuries.)

3. Beliefs and knowledge about HIV infection and safer sex

- The counsellor will determine exactly what you believe and know about HIV infection and Aids and he or she will correct errors or myths by providing accurate information about transmission and prevention.
- The counsellor may also ask you about your past and present sexual behaviour and provide information about safer sex practices and a healthier lifestyle. He or she should find out if you know how to practise safer sex and how to use a condom correctly. They will also supply you with condoms. Sex is natural and nothing to be ashamed of. Allow the counsellor to ask these questions, because that is the only way he or she can give you empowering information to enjoy sex safely.

4. Information about the test

The counsellor will ensure that you know exactly what the HIV test entails. The counsellor will explain the following points to you, and if he or she does not, you now know what questions to ask:

- There is a difference between being sero-positive and having Aids. The HIV antibody test is not a “test for Aids”. It indicates that a person has HIV antibodies in the blood and that the person is infected with HIV. It does not say when or how the infection occurred, or in what phase of infection the person is.
- The presence of HIV antibodies in the blood does not mean that the person is now immune to HIV. It means that he or she has been infected with HIV and that he or she can pass the virus on to others.
- The meaning of a positive and a negative test results.
- The meaning of the concept of the “window period”. The need for further testing will be emphasised if the person practises high-risk sexual behaviour and tests negative.
- The reliability of the testing procedures. A positive HIV antibody test result is always confirmed with a second test and the reliability of test results is usually high. False-positive or false-negative results may, however, occasionally occur despite the general reliability of HIV tests (e.g. a false negative test result because the person is in the window period).

- The testing procedure. Many clinics in South Africa use HIV antibody rapid tests, which means that the finger will be pricked to get a drop of blood. The results are available within 15 to 30 minutes. The counsellor will explain how blood is drawn for the Elisa test (if rapid testing is not available), where it is sent (if a rapid test is not used), when the results will be available and how the person will be informed of the outcome.

5. The implications of an HIV test result

The counsellor will discuss the possible personal, medical, social, psychological, ethical and legal implications of a positive test result with you prior to testing. He/she will inform you about all the advantages and disadvantages of testing. The following advantages can accrue from taking the test:

- Knowing the result may reduce the stress associated with uncertainty.
- One may begin to make rational plans for preparing oneself emotionally and spiritually to live with HIV.
- Symptoms can be confirmed, alleviated or treated.
- Prophylactic (preventative) treatment can be considered, for example for tuberculosis.
- Anti-retroviral treatment can be considered.
- Adjustments to one's lifestyle and sex life can protect oneself and one's sex partners from infection.
- One can make decisions about family planning and new sexual relationships.
- One can plan for future care of one's children.

The disadvantages that might accrue from taking an HIV test (especially if its result is positive) include:

- Possible limitations on life insurance and mortgages.
- Having to endure the social stigma associated with the disease.
- Possible problems in maintaining relationships and in making new friends.
- A possible refusal on the part of uninformed medical and dental personnel to treat an HIV-positive person. (A refusal to treat HIV-infected individuals of course goes against the provisions of the South African Constitution.)
- Possible dismissal from work (although it is illegal to dismiss people because they are HIV-positive).
- Possible rejection and discrimination by friends, family and colleagues.
- Emotional problems and a disintegration of one's life.
- Increased stress levels and uncertainty about the future.
- The stress and negative effects of maintaining a secret if the person decides not to disclose his or her test results.

The counsellor will tell you about medical treatments that are available which can help to keep you healthier for longer.

6. Anticipate the results

It is important to anticipate a positive HIV antibody result and to talk about how the client will deal with a positive test outcome. Anticipating a positive result helps the counsellor to ascertain the client's ability to deal with, and adjust to, a positive result. The counsellor also gains insight into some of the potential problems associated with a positive test outcome.

Preparation for the possibility of a positive test result, paves the way for more effective post-test counselling. In order to prepare you as client for the test result, the counsellor should ask the following questions:

- How would you feel if you tested negative? How would you feel if the test were to be negative but you were advised to be tested again because you may still be in the window period?
- What would your reactions and feelings be to a positive test? Would a positive test change your life? How? What negative changes would you anticipate? What positive changes can you imagine?
- Do you intend to tell others if you test positive? Who would you tell? Why that person? How would you tell them? Why would you tell them? Clients must be warned about people's possible reactions. Often those closest to the client cannot cope with such news. The counsellor must help clients to think not only of themselves but also of those who are to be told. (For example, if the client says to you: "The news will surely kill my old and frail mother", you may ask: "Why do you want your mother to know?"). Clients must also be warned that some people may not keep the information to themselves, and that this might have harmful effects for the client.
- How would you tell your sexual partner? If the test result is positive, the sexual partner also needs to be tested.
- How would a positive test result change the circumstances of your job, your family and your relationships? Would your relationships be improved or hindered by telling people you were HIV positive? What do you believe their reactions would be?
- Where would you seek medical help? How do you feel about a disease that requires a lot of care, lifestyle changes, commitment and discipline? Do you have members of your family or friends who could help you to be disciplined about your health? Could you take medication every four hours if necessary?
- Who could provide (and is currently providing) emotional and social support (family, friends, others)?

The choice to be tested remains the client's prerogative. The advantages of testing can be explained to clients, but clients should not be forced to be tested if they feel that they will not be able to deal with the results. The mere knowledge of people's HIV status will not necessarily protect them, or their loved ones, from infection.

People who prefer not to be tested should, however, live as if they are infected and practise safer sex at all times. People who suspect they are HIV infected should also refrain from donating blood.

7. Confidentiality of test results

The counsellor should stress the confidentiality of test results. The client's right to confidentiality must be respected at all times. If individuals choose to remain anonymous, they must be reassured that no information will be communicated without their prior permission to anyone.

The client's consent must be obtained before anyone can pass on any information about his or her HIV status to any other health care professional who also treats the client. If the counsellor explains why other health care professionals need to know about the client's HIV status, most clients will consent to this information being given out.

8. Informed consent

The decision to be tested can only be made by the client and their informed consent must be obtained prior to testing. Consenting to medical testing or treatment has two elements: information and permission. Before an HIV test can be done, the client must understand the nature of the test, and he/she must also give verbal or written permission to be tested. A client may never be misled or deceived into consenting to an HIV test.

Note to health care professionals: According to the law, health care professionals may not do an HIV test on a person unless he or she clearly understands what the purpose of the test is, what advantages or disadvantages testing may hold for him or her as client, why the health care professional wants this information, what influence the result of such a test will have on his or her treatment, and how his or her medical protocol will be altered by this information.

9. Information about giving the results and ongoing support

The counsellor will explain to you when, how and by whom the results of the test will be given. The counsellor will assure you of personal attention, privacy, confidentiality and ongoing support and advice if needed.

10. The waiting period

Waiting for the results of an HIV antibody test can be an extremely stressful period for the client. This waiting period (in cases where the rapid HIV antibody test is not being used) can last from two to 14 days, depending on where the test was done (whether by a private practice, a governmental health service or a rural clinic).

The results of rapid HIV antibody tests are, of course, available within 30 minutes. However, if the client has to wait for the test results, the counsellor should anticipate this difficult waiting period by discussing the following points with the client:

- Find out the names of people whom the client might contact for moral support while he or she waits for the results.
- Encourage the client to contact you or a colleague if they have any questions.
- Counsel the client on how to protect sex partners (e.g. to use condoms) in the waiting period.
- Encourage the client to do something enjoyable to keep himself or herself occupied while waiting for the results (e.g. hiking, going to the movies or playing soccer with friends).

Note to counsellors: Pre-HIV test counselling is extremely important. It should not only be seen as a preparation for the HIV test, but as a golden opportunity to educate people about HIV/Aids and safer sex. Remember that this may be the one and only time that you will see the client because he or she might decide not to be tested, or not to come back for the test results after all.

Post-HIV test counselling

Not many things in life could be as stressful as going back for HIV test results. For many clients it feels as if the counsellor holds the key to the future in his or her hands.

Although the post-HIV test counselling interview is separate from the pre-test counselling interview, it is inextricably linked to it. The pre-test counselling interview should have given the client a glimpse of what to expect in post-test counselling. Pre- and post-test counselling should preferably be done by the same person because the established relationship between the client and counsellor provides a sense of continuity for the client. The counsellor will also have a better idea of how to approach the post-test counselling because of what he or she experienced in the pre-test counselling.

Counselling after testing will depend on the outcome of the test - which may be a negative result, a positive result or an inconclusive result.

The counsellor should always ask the client if he or she is prepared to receive the results. In the case of the rapid HIV antibody test - where the results are available within minutes - ask the client if he/she is ready to receive the results immediately. Some clients need time to prepare for the results.

Counselling after a negative HIV test result

- For both the client and the counsellor, a negative HIV result is a tremendous relief.
- A negative test result could however give someone, who is frequently involved in high-risk behaviour, a false sense of security. It is therefore extremely important for the counsellor to counsel HIV-negative clients in order to reduce the chances of future infection. Advice about risk reduction and safer sex must therefore be emphasised.
- If you practise high risk sex behaviour and test negative, it does not mean that you are “immune” to HIV and that precautions are therefore unnecessary. Nobody is immune to HIV and everyone risks being infected if they do not change their behaviour.
- The possibility that the client is in the “window period” or that the negative test result may be a false negative should also be pointed out. If there is concern about the HIV status of the person, he or she should return for a repeat test after about three months and ensure that appropriate precautions are taken in the meanwhile.

Note to councellors: Don’t underestimate the extreme importance of counselling a client who tested HIV negative. This may be your only chance to talk to this person about his or her sexual practices, potential drug abuse and other risk behaviours, and to educate him or her about safer sex practices. Free condoms can be given out at this session together with advice on how to use them and where to get more when needed. Use this counselling session to prevent a future situation where somebody else has to give the client a positive HIV test result!

Counselling after a positive HIV test result

To communicate a positive test result to a client is a huge responsibility. The way people react to test results depends to a large extent on how thoroughly the counsellor has educated and prepared them both before and after the test.

When a test is positive, the following guidelines for counselling may prove useful for counsellors:

1. Sharing the news with the client

- Positive (as well as negative) test results should be given to the client personally.

- Feedback should take place in a quiet, private environment and enough time should be allowed for discussion.
- The news of a positive result ought to be communicated openly, honestly and without fuss. Simple and straightforward language should be used. Do not give the individual false hopes and (alternatively) do not paint a hopeless scenario.
- Choose neutral words when conveying a positive HIV test result. Don't attach value to the news by saying "I have bad news for you" - because such an attitude reflects a hopelessness in the mind of the counsellor. Rather say: "Mr Peterson, the results of your HIV test came back, and you are HIV positive".
- A positive result is NOT a death sentence and the counsellor's task is to convey optimism and hope.
- There are a few Don'ts that we need to observe when sharing a positive HIV test result with a client.
    - Don't lie or dodge the issue.
    - Don't beat about the bush or use delaying tactics. Come to the point.
    - Don't break the news in a corridor or any other public place.
    - Don't give the impression of being rushed, distracted or distant.
    - Don't interrupt or argue.
    - Don't say that "nothing can be done" because something can always be done to ease suffering.
    - Don't react to anger with anger.
    - Don't say "I know how you feel" because you don't.
    - Don't be afraid to admit ignorance if you don't know something.

2. Client reaction to a positive HIV test result

- Clients' responses to the news usually vary from one person to another, and may include shock, crying, agitation, stress, guilt, withdrawal, anger and outrage - some clients may even respond with relief.
- The counsellor should allow clients to deal with the news in their own way and give them the opportunity to express their feelings.
- The counsellor should show empathy, warmth and caring.
- Maintain neutrality and respond professionally to outbursts. Don't show surprise or make value-laden comments such as "There is no need to be upset with me!" Because the loss of health is a bereavement, it manifests with all the components of denial, anger, bargaining, depression and acceptance. The counsellor must respect the personal nature of an individual's feelings.

3. Responding to client needs

- People's needs, when they receive an HIV positive test result, vary, and the counsellor has to determine what those needs are and deal with them accordingly.
- Fear of pain and death are often the most serious and immediate problems and these can be dealt with in various ways. Talking to clients about their fears for the future is one of the most important therapeutic interventions that the counsellor can make.
- Often it is enough for the counsellor just to be “there” for the client and to listen to him or her.
- One of the major concerns for HIV positive people is whom to tell about their condition and how to break the news. It is often helpful to use role-play situations in which the client can practise communicating the news to others.
- In responding to a client's needs, an attitude of non-judgmental empathic attentiveness is more important than doing or saying specific things. Listening is more important than talking; being with more important than doing.

4. Crisis intervention

- Crisis intervention is often necessary after an HIV positive test result is given
- Make sure that the person has support after he or she leaves your office. A person in crisis should never be left alone: he or she should have somebody with whom to share the burden.
- Ask the client where he or she is going after leaving your office. Let the person think about and verbalise his or her plans for the next few hours. Although it is better for the client not to be alone, personal needs should be taken into consideration: Some people prefer to be alone and work through a crisis all by themselves.
- Be sensitive to the possibility of suicide. If the client shows any suicidal tendencies, emergency hospitalisation should be arranged if a friend or family member cannot be with the client.
- Make sure that your client does not leave your office without support to help him or her through the first few days.
- Don’t ever give an HIV-positive result on a Friday, because there are often no support systems available over weekends.

5. Follow-up visits

- When people hear that they are HIV positive, they usually experience so much stress that they absorb very little information.
- Follow-up visits are therefore necessary to give clients the opportunity to ask questions, talk about their fears and the various problems they encounter.

- Significant others, such as a lover, spouse or other members of the family, may be included in the session. During follow-up visits, clients should be offered a choice concerning their treatment.
- If health care professionals are not in a position to do follow-up counselling, information about relevant health services should be given. If there is a concern that the person might not return for follow-up counselling, information about available medical treatments such as anti-retroviral therapy, treatment of opportunistic infections, and social services for financial and ongoing emotional support should be given.
- Give the client a handout with whatever relevant information that he or she may need (such as the telephone numbers and addresses of Aids centres and other social services).

6. Support systems

- Find out what support systems are available to clients.
- Refer clients to support systems where people meet on a regular basis to talk about their difficulties or simply to relax and enjoy each other's company.
- Information about support systems such as the buddy system is usually available at the nearest Aids centre or from the offices of NGOs (non-governmental organisations) who work in the community.

7. Advice about health and sexuality

- Convey information about safer sex, infection control, health care in general and measures to strengthen the immune system.

8. Medical check-ups

- Encourage clients to go for regular medical check-ups to their family doctor or health clinic. Infections and opportunistic diseases can be prevented if treated in time.

Counselling after an indeterminate HIV test result

- In some cases an HIV test result can be "inconclusive", meaning that the result is ambiguous or indeterminate, and it is not possible at that stage to say if a person is HIV positive or not. (Explanation: A test result may be inconclusive because the test is cross-reacting with a non-HIV protein or because there has been insufficient time for full sero-conversion to occur since the person was exposed to HIV.)
- When a test result is inconclusive, other testing methods may be used to try to achieve a reliable result.
- The test can also be repeated after two weeks. If it is still inconclusive, it should be repeated at three, six and 12 months. If it is still inconclusive

after one year, it should be accepted that the person is not infected with HIV.

Impact of HIV infection on affected significant others

The significant others in an HIV positive person's life often need help themselves to come to terms with (1) their own fears and prejudices and (2) the implications and consequences of their loved one's sickness and ultimate death.

The counsellor can play a tremendous role in counselling the lovers, friends and family of the HIV-positive person in the practicalities of physical and emotional care. Affected significant others experience more or less the same psycho-social feelings as do their HIV-positive loved ones – the same feelings of depression, loneliness, fear, uncertainty, anxiety, anger, emotional numbness and, at times, hope.

The impact of HIV infection on affected others can be summarised as follows:

- Affected others often experience fear and anxiety about their own risk of infection.
- They are often angry with the infected person for “bringing this onto them”.
- They anticipate the loss of the HIV-positive person and issues of loss, bereavement and uncertainty are introduced into the relationship.
- They often feel unable to cope with the new demands that the infection place on them. They feel incompetent, unqualified and powerless in their interaction with the HIV-positive significant other.
- Responses to disclosure can range from involvement, caring and support on the one hand, to abandonment, indifference, and antagonism on the other.
- Affected others suffer in many ways as a result of untimely deaths. People who die of Aids are usually young (between 20 and 35 years old), and this leads to the “unnatural” situation where parents outlive their children. Grandparents who are preparing themselves for a quiet and contented old age now often find themselves forced to nurse and care for sick and dying children as well as grandchildren.
- Children suffer tremendously when their parents are infected, and the needs of children with infected parents are often neglected. There is no tradition of talking to children as equals and on an intimate basis in many African societies, and caregivers often report seeing “the suffering of children, who are too often hovering in the shadows of a sick room, seeing and hearing everything but never addressed directly”.
- Significant others often have to fulfil a role for which they are not trained, namely that of caregiver. They have to look after serious ill loved ones.

- Neurological complications and deterioration in mental functioning in the client can be extremely disturbing to significant others. They may feel that they are already losing their loved ones and this can precipitate an early grieving process

Helping the infected person and affected significant others

The main function of the HIV/Aids counsellor is to be supportive of his of her infected and affected clients, to listen to their problems and to empower them to solve their problems and better their lives.

1. Support and empowerment

- Compile, with each client, a list of their problems, and let them reflect on what they want.
- Assist the client to identify possible solutions to these problems. Encourage clients to come up with their own solutions because clients will be more likely to implement solutions that they find feasible and practical.
- Ask the client to make a list of his or her good qualities and possible limitations. He or she should, for instance, list his or her coping skills, describe the level of his or her self-esteem, analyse his or her personality style, communication style, sense of humour - and any other strengths and weaknesses that may be important.
- Examine and discuss possible solutions to whatever problems the client may have identified. Assess each solution in terms of the client's actual capabilities and capacity. Refrain from giving advice and suggesting solutions.
- Ask the client to write down the answers to the following question: “Why must I go on living?” Once this has been done, encourage him or her to work toward those goals and to make new and longer-term goals along the way. Clients should set goals that will give them a sense of purpose and pride (goals such as “I want to see my children growing up”).
- Identify the ways in which clients have dealt successfully with their problems in the past and help them (if necessary) to develop new coping skills.
- Empower clients to make their own decisions and to take control over their lives wherever and whenever possible.
- Make a note of any relationship problems between the client and his or her loved ones, friends and family, as well as between the client and other health providers.
- Encourage the client to call on peer support (buddy systems) or self-help groups. The counsellor may also be able to put clients in touch with each other on an individual basis (with the consent of the individuals involved).

2. Peer support (buddy system)

Clients should be encouraged to become involved in support groups or to form their own groups if none exist in their communities. The following issues are usually dealt with in peer support groups:

- Learning to live with HIV infection. Many of the people involved in the peer support group, may have already gone through the process of living with HIV. They can describe the medical and psychological problems they have experienced and the interventions they found most useful.
- Helping caregivers and loved ones handle the daily pressure of caring for sick people.
- Reducing stress and avoiding conflict. Buddies can exchange practical advice on how to overcome anxiety, depression and other psychological problems that can lead to stress and conflict.
- Deciding how best to talk about HIV/Aids to loved ones, friend and colleagues. Disclosing a diagnosis of HIV can be particularly stressful, and buddies can share ideas on what to say, to whom, when and how.
- Dealing with feelings of loneliness, depression, powerlessness and suicide. The peer support group can provide help and mutual support. Advice from people who have actually experienced those feelings personally and who have coped with them successfully is more valuable than theoretical information.
- Advice about sexual relations and the implications of safer sex behaviour. Peer support groups can discuss all aspects of these problems and opportunities and give each other good advice about safer sex practices. Peer commitment to safer sex also helps to make these practices socially acceptable, attractive and sustainable.

Bereavement counselling

The bereavement experienced by a person who has lost a loved one and the bereavement experienced by a terminally ill or dying person are very similar.

Both people experience a grievous sense of loss: in the first case, one experiences the loss of a loved one, and in the second case, one experiences the loss of one's future, one's hopes, one's loved ones, one's health, self-esteem, well-being and one's dignity as a human being. In either case, people are confronted with their own mortality.

Terminally ill persons are directly confronted by their own imminent death - the imminence of which becomes more pressing as the disease progresses – while persons who have lost a loved one are indirectly confronted with the

possibility and spectacle of their own future death through the death of the loved one. It is therefore understandable that the process of bereavement is often very similar for both those who are dying and those who are forced to witness death.

In all cases where HIV-infected people are still leading relatively normal and healthy lives for extended periods, the counsellor needs to facilitate a process of reinvestment in life. This is also an important element in the counselling of a person who has lost or is in the process of losing a loved one.

Bereaved people should actively ***work through*** their grief in their own time. Bereavement is a process that cannot be rushed.

Kübler-Ross's stages of dying

Kübler-Ross identified the following "stages" of dying…

- **Denial and isolation:** *In this stage, the person denies that death is really going to take place.* This reaction is commonly associated with any kind of terminal illness. However, denial is usually only a temporary defence and is eventually replaced with increased awareness when the person is confronted with such matters as financial considerations, unfinished business and worry about surviving family members.
- **Anger:** *The dying person realises that denial can no longer be maintained, and very often, feelings of anger, resentment, rage and envy follow.* In this stage, the dying person wonders **"why"** he has to die. It can be difficult to care for a person in this stage since the anger can be displaced and projected onto the nurses, social worker, doctor, family member, etc. or even God. The realisation of loss becomes great, and those who symbolise life, energy, and competent functioning are especially salient targets of the dying person's resentment and jealousy.
- **Bargaining:** *In this phase, the dying person develops the hope that death can somehow be postponed or delayed.* Some persons enter into a bargaining or negotiation - often with God - as they try to delay their death. Psychologically the person is saying "Yes me, but…". In exchange for a few more days, weeks, or months of life, the person promises to lead a reformed life dedicated to God or to the service of others.
- **Depression:** *Here the dying person comes to accept the certainty of death.* This can be evident in several ways. The dying person may become silent, may refuse visitors, and may spend much of the time crying or grieving. This behaviour should be perceived as normal in these circumstances and is actually an effort to disconnect the self from all love objects. Efforts to cheer up the dying person at this stage should be discouraged, because the dying person has a need to contemplate impending death.
- **Acceptance:** *The dying person develops a sense of peace; an acceptance of one's fate; and, in many cases, a desire to be left alone.* In this stage,

feelings and physical pain may be virtually absent. Kübler-Ross sees this stage as the end of the dying struggle, the final resting stage before death.

Kübler-Ross never intended the stages to be an invariant sequence of steps toward death, and individual variation should be recognised.

The four tasks of mourning

According to Worden (1999) there are four tasks of mourning.

Accepting the reality of the loss: There are two aspects of death bereaved people must accept. The first one involves accepting that the person has died and will not come back. The second one involves facing the changes of the realities of life, brought about by the loss of a loved one.

Experiencing the pain of grief: Everyone who loses someone they love experiences the pain of grief. Sometimes society pressurises people who are in mourning to get on with their lives and not be preoccupied with the loss. This results in the bereaved feeling lonely, with no one to share the experiences - often complicating the grieving process. It is for this reason that the mental health provider must offer the bereaved a space to share their grief and to feel the pain.

Adjusting to an environment in which the deceased is missing: The bereaved can be assisted to living without the deceased person and to make decisions independently.

Emotionally relocating the loved one: The bereaved has to find a new place in his or her life for their lost loved one - a place that will allow him or her to move forward with life and form new relationships.

HIV/AIDS Counselling principles and procedures

Here are some useful counselling principles and procedures from Nefale (2001).

- Help the survivor **actualise** the loss
- Help the survivor to identify and express feelings
- Assist living without the deceased
- Facilitate emotional relocation of the deceased
- Provide time to grieve
- Interpret "normal" behaviour
- Allow for individual and cultural differences
- Provide continuing support
- Examine defences and coping styles
- Identify pathology and refer

Useful techniques in bereavement counselling

Counselling the loved ones of someone that has died from Aids or any terminal illness for that matter is a very difficult thing. Here are some useful techniques in bereavement counseling

Evocative language: The counsellor can use tough words to evoke language, e.g. “your son is dead” versus “you lost your son”. This language will assist the client in perceiving the reality of the loss and can stimulate some of the painful feelings that need to be felt. Also speaking of the deceased in the past tense can be helpful.

The use of symbols: The counsellor can ask clients to bring photo’s of the deceased to counselling sessions. This creates a sense of immediacy of the deceased and a concrete focus for talking **to** the deceased rather than talking **about** him/her. Letters written by the deceased can also be useful as well as audio/videotapes of the deceased. Articles of clothing and jewellery can also be used. The counsellor needs to be sensitive to the client’s culture of doing things and deal with what the client is comfortable with.

Writing: The counsellor can ask the client to write a letter(s) to the deceased expressing thoughts and feelings. This can help take care of unfinished business by expressing things that need to be said to the deceased. Keeping a journal of one’s grief experience or writing poetry can also facilitate the expression of feelings and lend personal meaning to the experience of loss.

Drawing: The counsellor can also ask the client to draw pictures that reflect his or her feelings as well as experiences held with the deceased. This works well with children, but can also be used with adults.

Role playing: The counsellor can assist the bereaved to role play various situations that they fear or feel awkward about, as one way to build coping skills. The counsellor can enter into the role play, either as a facilitator or to model possible new behaviours for the client.

Cognitive restructuring: The underlying assumption of the cognitive restructuring technique is that our thoughts influence our feelings, particularly covert thoughts and self-talk that constantly go on in our minds. By helping the client to identify these thoughts and reality test them for accuracy or overgeneralisations, the counsellor can help to lessen the dysphoric feelings triggered by certain irrational thoughts such as “no one will ever love me again”.

Memory book: One activity a bereaved family can do together is to make a memory book of the lost family member. This book can include stories about family events and snapshots, poems and drawings made by various family

members, including children. This activity can help the family to reminisce and eventually to mourn a more realistic image of the dead person. In addition, children can go back to revisit this memory book in order to reintegrate the loss into their growing and changing lives.

Directed imagery: Helping the person to imagine the deceased, either with their eyes closed or visualising their presence in an empty chair and then encouraging them to say what they need to say to the deceased can be very powerful techniques. The power comes not from the imagery, but from being in the present and again, talking to the person, rather than talking about the person.

The purpose of all these techniques is to encourage the fullest expression of thoughts and feelings regarding the loss, including regrets and disappointment.

Voluntary Counseling and Testing

VCT for HIV usually involves two counseling sessions: one prior to taking the test known as "pre-test counseling" and one following the HIV test when the results are given, often referred to as "post-test counseling". Counseling focuses on the infection (HIV), the disease (AIDS), the test, and positive behavior change. VCT has become popular in many parts of Africa as a way for a person to learn their HIV status. VCT centers and counselors often use rapid HIV tests that require a drop of blood or some cells from the inside of one's cheek; the tests are cheap, require minimal training, and provide accurate results in about 15 minutes.

Circumcision and HIV

Over forty epidemiological studies have been conducted to investigate the **relationship between male circumcision and HIV infection**. Reviews of these studies have reached differing conclusions about whether circumcision could be used as a prevention method against HIV. Experimental evidence was needed to establish a causal relationship between lack of circumcision and HIV, so three randomized controlled trials were commissioned as a means to reduce the effect of any confounding factors. Trials took place in South Africa, Kenya and Uganda. All three trials were stopped early by their monitoring boards on ethical grounds, because those in the circumcised group had a lower rate of HIV contraction than the control group. The results showed that circumcision reduced vaginal-to-penile transmission of HIV by 60%, 53%, and 51%, respectively. A meta-analysis of the African randomised controlled trials found that the risk in circumcised males was 0.44 times that in uncircumcised males, and reported that 72 circumcisions would need to be performed to prevent one HIV infection. The authors also stated that using circumcision as a means to reduce HIV infection would, on a national level, require consistently safe sexual practices to maintain the protective benefit.

As a result of these findings, the WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) stated that male circumcision is an efficacious intervention for HIV prevention but should be carried out by well trained medical professionals and under conditions of informed consent (parents consent for their infant boys Both the WHO and CDC indicate that circumcision may not reduce HIV transmission from men to women, and that data is lacking for the transmission rate of men who engage in anal sex with a female partner. The joint WHO/UNAIDS recommendation also notes that circumcision only provides partial protection from HIV and should never replace known methods of HIV prevention.

Langerhans cells and HIV transmission

Langerhans cells are part of the human immune system. Three studies identified high concentrations of Langerhans and other "HIV target" cells in the foreskin and Szabo and Short suggested that the Langerhans cells in the foreskin may provide an entry point for viral infection. McCoombe, Cameron, and Short also found that the keratin is thinnest on the foreskin and frenulum. Van Howe, Cold and Storms criticised Szabo and Short's suggestion as "pure speculation. Fleiss, Hodges and Van Howe had previously stated a belief that the prepuce has an immunological function. Waskett criticized their specific hypothesis on technical grounds. A study published in 2007 by de Witte and others said that langerin, produced by Langerhans cells, is a natural barrier to HIV-1 transmission by Langerhans cells. Dowsett (2007) questioned why it was just males that were being encouraged to circumcise: "Langerhans cells occur in the clitoris, the labia and in other parts of both male and female genitals, and no one is talking of removing these in the name of HIV prevention.

Module 2: Counseling inform of Suicide Intervention

Suicide intervention or **suicide crisis intervention** is direct effort to stop or prevent persons attempting or contemplating suicide from killing themselves. Current medical advice concerning people who are attempting or seriously considering suicide is that they should immediately go or be taken to the nearest emergency room, or emergency services should be called immediately by them or anyone aware of the problem. Modern medicine treats suicide as a mental health issue. According to medical practice, severe suicidal ideation, that is, serious contemplation or planning of suicide, is a medical emergency and that the condition requires immediate emergency medical treatment.

In the United States, individuals who express the intent to harm themselves are automatically determined to lack the *present mental capacity* to refuse treatment, and can be transported to an emergency department against their will. An emergency physician there will determine whether or not inpatient care at a mental health care facility is warranted. This is sometimes referred to as being "committed." If the doctor determines involuntary commitment is needed,

the patient is hospitalized and kept under observation until a court hearing is held to determine the patient's *competence*.

Individuals suffering from depression are considered a high-risk group for suicidal behavior. When depression is a major factor, successful treatment of the depression usually leads to the disappearance of suicidal thoughts. However, medical treatment of depression is not always successful, and lifelong depression can contribute to recurring suicide attempts.

Medical personnel frequently receive special training to look for suicidal signs in patients. Suicide hotlines are widely available for people seeking help. However, the negative and often too clinical reception that many suicidal people receive after relating their feelings to health professionals (e.g. threats of institutionalization, increased dosages of medication, the social stigma) may cause patients to remain more guarded about their mental health history or suicidal urges and ideation.

First Aid for Suicide Ideation

Medical professionals advise that people who have expressed plans to kill themselves be encouraged to seek medical attention immediately. This is especially relevant if the means (weapons, drugs, or other methods) are available, or if the patient has crafted a detailed plan for executing the suicide. Mental health professionals suggest that people who know a person whom they suspect to be suicidal can assist him or her by asking directly if the person has contemplated committing suicide and made specific arrangements, has set a date, etc. Posing such a question *does not* render a previously non-suicidal person suicidal. According to this advice, the person questioning should seek to be understanding and empathetic above all else since a suicidal person will often already feel ashamed or guilty about contemplating suicide so care should be taken not to exacerbate that guilt.

Mental health professionals suggest that an affirmative response to these questions should motivate the immediate seeking of medical attention, either from that person's doctor, or, if unavailable, the emergency room of the nearest hospital.

If the prior interventions fail, mental health professionals suggest involving law enforcement officers. While the police do not always have the authority to stop the suicide attempt itself, in some countries including some jurisdictions in the US, killing oneself is illegal.

In most cases law enforcement does have the authority to have people involuntarily committed to mental health wards. Usually a court order is required, but if an officer feels the person is in immediate danger he/she can order an involuntary commitment without waiting for a court order. Such

commitments are for a limited period, such as 72 hours – which is intended to be enough time for a doctor to see the person and make an evaluation. After this initial period, a hearing is held in which a judge can decide to order the person released or can extend the treatment time. Afterwards, the court is kept informed of the person's condition and can release the person when they feel the time is right to do so. Legal punishment for suicide attempts is extremely rare.

Mental Health Treatment

Treatment, often including medication, counseling and psychotherapy, is directed at the underlying causes of suicidal thinking. Clinical depression is the most common treatable cause, with alcohol or drug abuse being the next major categories.

Other psychiatric disorders associated with suicidal thinking include bipolar disorder, schizophrenia, Borderline personality disorder, Gender identity disorder and eating disorders. Suicidal thoughts provoked by crises will generally settle with time and counseling. Severe depression can continue throughout life even with treatment and repetitive suicide attempts or suicidal ideation can be the result.

Methods for disrupting suicidal thinking include having family members or friends tell the person contemplating suicide about who else would be hurt by the loss, citing valuable and productive aspects of the patient's life, and provoking simple curiosity about the victim's own future.

During the acute phase, the safety of the person is one of the prime factors considered by doctors, and this can lead to admission to a psychiatric ward or even involuntary commitment.

Suicide Prevention

Various suicide prevention strategies are suggested by Mental Health professionals:

- Promoting mental resilience through optimism and connectedness.
- Education about suicide, including risk factors, warning signs, and the availability of help.
- Increasing the proficiency of health and welfare services in responding to people in need. This includes better training for health professionals and employing crisis counseling organizations.
- Reducing domestic violence and substance abuse are long-term strategies to reduce many mental health problems.
- Reducing access to convenient means of suicide (e.g., toxic substances, handguns).

- Reducing the quantity of dosages supplied in packages of non-prescription medicines e.g., aspirin.
- Interventions targeted at high-risk groups.

Research on Suicide Prevention

Research into suicide is published across a wide spectrum of journals dedicated to the biological, economic, psychological, medical and social sciences. In addition to those, a few journals are exclusively devoted to the study of suicide (suicidology), most notably, Crisis, Suicide and Life Threateni Stress Management

Historical Foundations of Suicide prevention

Walter Cannon and Hans Selye used animal studies to establish the earliest scientific basis for the study of stress. They measured the physiological responses of animals to external pressures, such as heat and cold, prolonged restraint, and surgical procedures, then extrapolated from these studies to human beings.

Subsequent studies of stress in humans by Richard Rahe and others established the view that stress is caused by distinct, measurable life stressors, and further, that these life stressors can be ranked by the median degree of stress they produce (leading to the Holmes and Rahe Stress Scale). Thus, stress was traditionally conceptualized to be a result of external insults beyond the control of those experiencing the stress. More recently, however, it has been argued that external circumstances do not have any intrinsic capacity to produce stress, but instead their effect is mediated by the individual's perceptions, capacities, and understanding.

Module 3: Stress, Anxiety and Tension Management

All of us experience anxiety, stress or tension at some or other stage in our lives. If we do not cope with it immediately and deliberately it might overwhelm us and immobilise us for the tasks that we have to perform.

It forms the cornerstone of all forms of dis-ease. Therefore it is necessary to know about the effects of anxiety, stress and tension and how we can cope with it. In this case I am talking about stress as dis-ease and not as a disease. It is a symptom of a disease when the thyroid gland is malfunctioning for instance. Then obviously you should get treatment for the thyroid gland that is malfunctioning and that will relieve the stress.

Anxiety, stress and tension are terms that are often used as synonyms. According to the dictionary, anxiety refers to a state of being anxious about eminent danger; being excessively concerned about the future. Anxiety, however, is usually not linked to a specific person, situation or experience

which is feared. It is a vague, undefined, tense feeling of dread that one experiences and which is difficult to control.

Stress refers to an effort or demand upon physical or mental energy. Stress produces the same feelings as anxiety but it is usually linked to a specific significant other person, situation or experience that one fears. Examples would include an examination, assignment or a superior person. Tension on the other hand refers to mental strain or excitement; a strained state or relationship. If the symptoms are experienced acutely, it is referred to as a panic attack.

All these definitions have in common the fact that individuals experience excessive uneasiness and that they worry as a result of perceived (excessive or dangerous) demands that are made on them on an interpersonal level. The anxiety, worry or tenseness could result in the impairment of social, occupational, physical and other important areas of functioning. One could also say that individuals experience an excessive sensitivity for other's opinions, attitudes and demands.

Symptoms
Experiencing anxiety, stress or tension can lead to symptoms such as:

(A) Psychosomatic symptoms

- Getting tired very easily
- Muscle tension
- Palpitations - a pounding heart or an accelerated heart rate
- Sweating (cold sweat) or hot flushes
- Shortness of breath, a feeling of being choked or a smothering sensation with pain in the chest
- Nausea or abdominal distress
- Feeling numb or experiencing tingling sensations in certain parts of the body
- Experiencing a dry mouth and the urge to swallow repeatedly
- Diarrhoea
- Impotence or an excessive need for sex
- Asthma
- Feeling dizzy, unsteady, lightheaded or faint

(B) Emotional symptoms

- Feeling depressed and downhearted at times
- Feeling detached from oneself
- Fear of losing control or going crazy
- Fear of dying

- Intense apprehension, fearfulness, or terror, often associated with feelings of impending doom

(C) Intellectual symptoms

- Difficulty concentrating on a specific task or experiencing the mind going blank (clouding of consciousness)
- Forgetfulness, resulting from preoccupation with the problem

(D) Behavioural symptoms

- Restlessness, feeling keyed up or on edge
- Trembling or shaking
- Short tempered
- Withdrawal from interpersonal interaction
- Excessive smoking, sleeping and/or drinking
- Sleep disturbances (finding it difficult to fall asleep or experiencing nightmares, sleeping excessively or restless sleep - waking up tired)
- Not feeling hungry or eating excessively
- Slow psychomotor co-ordination

Very often a person who experiences stress is inclined to shy away from interpersonal contact and is thus inclined to bottle up feelings instead of sharing them with others. This bottling up of feelings and the corresponding tension could lead to psychosomatic symptoms as well as disturbed sleep, sexual and eating patterns. Your need for sex might be diminished or you could experience an excessive need for it to comfort you. You also might not feel hungry.

In an attempt to overcome anxiety or tension you might resort to excessive smoking, sleeping and drinking. When stress is prevalent, depression is underlying or dormant. Once you give up handling and competing with the problems creating the stress, depression sets in. What can we do about it if we experience stress and anxiety or underlying depression?

How to cope with stress

Peter discovered that he was in debt. This realization made it impossible for him to sleep. He became very anxious and depressed and wanted to commit suicide. He complained about it to a good friend. The friend listened patiently as Peter told him of all his problems, but when he replied, he made no mention of the debts. This surprised Peter very much.

Instead of discussing the debts, the friend talked about what Peter owned, about his money, and about the friends who were ready to help him. Suddenly the disturbed Peter saw his problems in a new light. He stopped wasting his energy on problems and debts and concentrated on the abilities he actually

had. He then discovered that he had enough power and resources to solve his problem.

This story teaches us that a healthy person is not one who is free of problems, but one who deals with them. One day's happiness can make a person forget his/her misfortune, and one day's misfortune can make a person forget his/her past happiness.

- Your subjective perception could be different:
  As I have mentioned, anxiety or stress implies an over-sensitivity to other's opinions, attitudes and demands. It is the meaning that you attach to significant other people's opinions, attitudes and demands that brings about the tension.

  This being the case, then surely communication between the concerned parties should alleviate the matter. It sounds easy enough but we all have reservations about communicating about matters of a personal nature. We always think: 'What will he think of me if I told him this problem that I experience', or ' She would think I am stupid to have such a problem,' or 'Why can't I just cope with problems like anybody else?' or 'I am sure I am the only one with such a problem, nobody will understand me.'

  Most emotional problems are related to the perceptions and expectations we have of significant other people. The questions above confirm this view. One could thus also say that in one's (subjective) definition of the problem lies the solution to it as well.

- Keep fit:
  To be able to perceive and handle problems effectively, one must also be as physically fit as possible. Tiredness can negatively influence the perception of, definition of and possible solution of a problem. The problem may then be perceived as overwhelming and insoluble.
- Your definition of the problem could be different:
  The solution to a problem lies in its meaning, perception and definition. If you define a problem as overwhelming, it will appear insoluble. Furthermore, if you think about a problem on your own, you will only have one point of view.

  In the example earlier, Peter's friend introduced a different perspective and by implication a (different) solution to the problem. When a person is gets ill in the West, they say he must have a rest. He is visited by a few people and visits are socially controlled. In the East, when a person gets ill, his bed is placed in the living room.

The sick person is the centre of attention and he is visited by many family members and friends. If visitors stayed away, it would be seen as uncivil and as a lack of sympathy. In this way relationships are confirmed. In the West relationships very often become severed when a person becomes ill and the sick person is "forgotten" at his/her office until he/she returns. He/she does not experience being missed by colleagues and friends.

- Begin to communicate about the problem:
  So, if you find it difficult to talk to someone about your problems or negative experiences, find a psychologist or a good friend and start to practise talking to him/her first. Maybe that will give you enough courage to talk to others as well. By sharing a problem and feeling understood, the impact of a problem is alleviated.

  There is a saying: "Nature is explained but people are understood." There is no need for you to ever explain your behaviour if you feel you have done the best you can. We only need to understand each other.

- Take a tranquilliser for stress situations:
  Very often people ask whether or not it may be simpler to take a tranquilliser to alleviate the anxiety or tension. There are times when tranquillisers may come in handy on a short term basis.

  For example when a loved one dies and you find it difficult to cope with the emotional impact of the event or if you are the bridegroom who has to make a speech at your wedding and you suffer from stage fright, tranquillisers could help you cope with a temporary tense situation. (The bridegroom might however pay for it in another way later on that evening - much to his embarrassment! Tranquillisers and sex do not really work together.)

  Feeling tense could be compared to the waves of the sea. You are not equally tense at all times, just as the intensity of the waves differ at different times. The tenseness builds up to a peak and then calms down a bit, similar to high tide when the sea is much more active. The waves come and go.

  The tranquilliser succeeds in cutting out peak emotional experiences so that you do not experience it as so overwhelming. The 'wave' of emotion can thus not develop fully under the influence of a tranquilliser and in this way you are protected for as long as you take the tranquilliser.

- Learn to ride the wave of emotion:
  But can you carry on taking the medication for ever? Would it not be better to learn how to surf, so that you can ride the waves of emotion

when they come? For this reason it is important to talk to as many people as possible about your experiences, especially to experts. If you bottle feelings up, you are 'freezing' the emotional wave and the body is kept in a state of readiness, like a horse that is ready to race. The adrenalin is still pumping and the heart rate is still high to keep you in that state of readiness.

Also many of the corresponding symptoms that were mentioned earlier, still prevail. Obviously the body cannot be kept in a state of readiness indefinitely and something must give in. Usually it is the heart which works the hardest and is the most vulnerable. So, does it pay to bottle up (and freeze emotions)? Definitely not.

Models of Stress Management

Transactional Model

Richard Lazarus and Susan Folkman suggested in 1984 that stress can be thought of as resulting from an “imbalance between demands and resources” or as occurring when “pressure exceeds one's perceived ability to cope”. Stress management was developed and premised on the idea that stress is not a direct response to a stressor but rather one's resources and ability to cope mediate the stress response and are amenable to change, thus allowing stress to be controllable.

In order to develop an effective stress management programme it is first necessary to identify the factors that are central to a person controlling his/her stress, and to identify the intervention methods which effectively target these factors. Lazarus and Folkman's interpretation of stress focuses on the transaction between people and their external environment (known as the Transactional Model). The model conceptualizes stress as a result of how a stressor is appraised and how a person appraises his/her resources to cope with the stressor. The model breaks the stressor-stress link by proposing that if stressors are perceived as positive or challenging rather than a threat, and if the stressed person is confident that he/she possesses adequate rather than deficient coping strategies, stress may not necessarily follow the presence of a potential stressor. The model proposes that stress can be reduced by helping stressed people change their perceptions of stressors, providing them with strategies to help them cope and improving their confidence in their ability to do so.

Health Realization/Innate Health Model

The health realization/innate health model of stress is also founded on the idea that stress does not necessarily follow the presence of a potential stressor. Instead of focusing on the individual's appraisal of so-called stressors in

relation to his or her own coping skills (as the transactional model does), the health realization model focuses on the nature of thought, stating that it is ultimately a person's thought processes that determine the response to potentially stressful external circumstances. In this model, stress results from appraising oneself and one's circumstances through a mental filter of insecurity and negativity, whereas a feeling of well-being results from approaching the world with a "quiet mind," "inner wisdom," and "common sense".

This model proposes that helping stressed individuals understand the nature of thought--especially providing them with the ability to recognize when they are in the grip of insecure thinking, disengage from it, and access natural positive feelings--will reduce their stress.

Techniques of Stress Management

There are several ways of coping with stress. Some techniques of time management may help a person to control stress. In the face of high demands, effective stress management involves learning to set limits and to say "No" to some demands that others make. The following techniques have been recently dubbed “Destressitizers” by The Journal of the Canadian Medical Association. A destressitizer is any process by which an individual can relieve stress. Techniques of stress management will vary according to the theoretical paradigm adhered to, but may include some of the following:

Measuring Stress

Levels of stress can be measured. One way is through the use of the Holmes and Rahe Stress Scale to rate stressful life events. Changes in blood pressure and galvanic skin response can also be measured to test stress levels, and changes in stress levels. A digital thermometer can be used to evaluate changes in skin temperature, which can indicate activation of the fight or flight response drawing blood away from the extremities.

Stress management has physiological and immune benefit effects.

Effectiveness of Stress Management

Positive outcomes are observed using a combination of non-drug interventions:

- treatment of anger or hostility,
- autogenic training
- talking therapy (around relationship or existential issues)
- biofeedback
- cognitive therapy for anxiety or clinical depression

Module 4: Counseling psychology

Counseling psychology is a psychological specialty that encompasses research and applied work in several broad domains: counseling process and outcome; supervision and training; career development and counseling; diversity and multiculturalism; and prevention and health. Some unifying themes among counseling psychologists include a focus on assets and strengths, person-environment interactions, educational and career development, brief interactions, and a focus on intact personalities.

Two differences in particular may distinguish the field of counseling from the field of counseling psychology: first, counseling is almost entirely an applied field: that is, the occupation of counselors is generally counseling and psychotherapy. In contrast, counseling psychology is both a research and applied field; applied work might include teaching, consultation, and clinical work, which in turn could include supervision, assessment, and forensic evaluation, in addition to counseling or psychotherapy. A second distinction is the breadth of topics encompassed by counseling psychology. In addition to studying and teaching *counseling*, counseling psychologists also engage in research in areas such as career development, culture, ethnicity, gender, identity development, personality, sexual orientation, race, and research methodology.

Employment settings

Counseling psychologists are employed in a variety of settings depending on the services they provide and the client populations they serve. Some are employed in colleges and universities as teachers, supervisors, researchers, and service providers. Others are employed in independent practice providing counseling, psychotherapy, assessment, and consultation services to individuals, couples/families, groups, and organizations. Additional settings in which counseling psychologists practice include community mental health centers, Veterans Administration Medical Centers and other facilities, family services, health maintenance organizations, rehabilitation agencies, business and industrial organizations and consulting within firms.

Counseling Process and Outcome

Counseling psychologists are interested in answering a variety of research questions regarding counseling process and outcome. Counseling process might be thought of as how or why does counseling happen and progress. Counseling outcome addresses whether or not counseling is effective, under what conditions is counseling effective, and what outcomes are considered effective- such as symptom reduction, behavior change, or quality of life improvement. Topics commonly explored in the study of counseling process and outcome include therapist variables, client variables, the counseling or

therapeutic relationship, cultural variables, process and outcome measurement, mechanisms of change, and process and outcome research methods.

Therapist variables: These include characteristics of a counselor or psychotherapist, as well as therapist technique, behavior, theoretical orientation and training. In terms of therapist behavior, technique and theoretical orientation, research on adherence to therapy models has found that adherence to a particular model of therapy can be helpful, detrimental, or neutral in terms of impact on outcome (Imel & Wampold, 2008). Research on the impact of training and experience is still somewhat contradictory and even counter-intuitive. For example, a recent study found that age-related training and experience, but not amount or quality of contact with older people, is related to older clients. However, a recent meta-analysis of research on training and experience suggests that experience level is only slightly related to accuracy in clinical judgment Higher therapist experience has been found to be related to less anxiety, but also less focus. This suggests that there is still work to be done in terms of training clinicians and measuring successful training.

Client variables: Client characteristics such as help-seeking attitudes and attachment style have been found to be related to client use of counseling, as well as expectations and outcome. Stigma against mental illness can keep people from acknowledging problems and seeking help. Public stigma has been found to be related to self-stigma, attitudes towards counseling, and willingness to seek help. In terms of attachment style, clients with avoidant styles have been found to perceive greater risks and fewer benefits to counseling, are less likely to seek professional help, compared with securely attached clients. Those with anxious attachment styles perceive greater benefits as well as risks to counseling. Educating clients about expectations of counseling can improve client satisfaction, treatment duration and outcomes, and is an efficient and cost-effective intervention.

Counseling relationship: The relationship between a counselor and client is the feelings and attitudes that a client and therapist have towards one another, and the manner in which those feelings and attitudes are expressed. It may be thought of in three parts: transference counter transference, working alliance, and the real- or personal- relationship. Another theory about the function of the counseling relationship is known as the secure-base hypothesis, which is related to attachment theory. This hypothesis proposes that the counselor acts as a secure-base from which clients can explore and then check in with. Secure attachment to one’s counselor and secure attachment in general have been found to be related to client exploration. Insecure attachment styles have been found to be related to less session depth, compared to sessions of securely attached clients

Cultural variables: Counseling psychologists are interested in how culture relates to help-seeking and counseling process and outcome. Helms' racial identity model can be useful for understanding how the relationship and counseling process might be affected by the client's and counselor's racial identity. Recent research suggests that clients who are Black are at risk for experiencing racial micro-aggressions from counselors who are White.

Efficacy for working with clients who are lesbians, gay men, or bisexual might be related to therapist demographics, gender, sexual identity development, sexual orientation, and professional experience. Clients who have multiple oppressed identities might be especially at-risk for experiencing unhelpful situations with counselors, so counselors might need help with gaining expertise for working with clients who are transgender, lesbian, gay, bisexual, or transgender people of color, and other oppressed populations. .

Gender role socialization can also present issues for clients and counselors. Implications for practice include being aware of stereotypes and biases about male and female identity, roles and behavior such as emotional expression.

Outcome measurement: Counseling outcome measures might look at a general overview of symptoms, symptoms of specific disorders, or positive outcomes, such as subjective well-being or quality of life. The Outcome Questionnaire-45 is a 45 item self-report measure of psychological distress. An example of disorder specific measure would be the Beck Depression Inventory. The Quality of Life Inventory is a 17 item self-report life satisfaction measure.

Process and Outcome Research Methods

Counseling process and outcome research employs a variety of research methodologies to answer questions about if, how, and why counseling works. Quantitative methods include randomly controlled clinical trials, correlation studies over the course of counseling, or laboratory studies about specific counseling process and outcome variables. Qualitative research methods can involve conducting, transcribing and coding interviews; transcribing and/or coding therapy sessions; or fine-grain analysis of single counseling sessions or counseling cases.

Psychotherapy

Psychotherapy is an intentional interpersonal relationship used by trained psychotherapists to aid a client or patient in problems of living. It aims to increase the individual's well-being. Psychotherapists employ a range of techniques based on experiential relationship building, dialogue, communication and behavior change and that are designed to improve the mental health of a client or patient, or to improve group relationships (such as in a family). Psychotherapy may also be performed by practitioners with a

number of different qualifications, including psychologists, marriage and family therapists, occupational therapists, licensed clinical social workers, counselors, psychiatric nurses, psychoanalysts, and psychiatrists.

Etymology

The word psychotherapy comes from the Ancient Greek words *psyche*, meaning breath, spirit, or soul and *therapies* or *therapeuein*, to nurse or cure. Its use was first noted around 1890. It is defined as the relief of distress or disability in a one person by another, using an approach based on a particular theory or paradigm, and that the agent performing the therapy has had some form of training in delivering this. It is these latter two points which distinguish psychotherapy from other forms of counseling or care giving.

Forms

Most forms of psychotherapy use spoken conversation. Some also use various other forms of communication such as the written word, artwork, drama, narrative story or music. Psychotherapy occurs within a structured encounter between a trained therapist and client(s). Purposeful, theoretically based psychotherapy began in the 19th century with psychoanalysis; since then, scores of other approaches have been developed and continue to be created.

Therapy is generally employed in response to a variety of specific or non-specific manifestations of clinically diagnosable and/or existential crises. Treatment of everyday problems is more often referred to as counseling (a distinction originally adopted by Carl Rogers). However, the term counseling is sometimes used interchangeably with "psychotherapy".

Whilst some psychotherapeutic interventions are designed to treat the patient employing the medical model, many psychotherapeutic approaches do not adhere to the symptom-based model of "illness/cure". Some practitioners, such as humanistic therapists, see themselves more in a facilitative/helper role. As sensitive and deeply personal topics are often discussed during psychotherapy, therapists are expected, and usually legally bound, to respect client or patient confidentiality. The critical importance of confidentiality is enshrined in the regulatory psychotherapeutic organizations' codes of ethical practice.

Psychotherapy systems

There are several main broad systems of psychotherapy:

- Psychoanalytic - it was the first practice to be called a psychotherapy. It encourages the verbalization of all the patient's thoughts, including free associations, fantasies, and dreams, from which the analyst formulates

the nature of the unconscious conflicts which are causing the patient's symptoms and character problems.

- Cognitive behavioral - generally seeks by different methods to identify and transcend maladaptive cognition, appraisal, beliefs and reactions with the aim of influencing destructive negative emotions and problematic dysfunctional behaviors.
- Psychodynamic - is a form of depth psychology, the primary focus of which is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension. Although its roots are in psychoanalysis, psychodynamic therapy tends to be briefer and less intensive than traditional psychoanalysis.
- Existential - is based on the existential belief that human beings are alone in the world. This isolation leads to feelings of meaninglessness, which can be overcome only by creating one's own values and meanings.
- Humanistic - emerged in reaction to both behaviorism and psychoanalysis and is therefore known as the Third Force in the development of psychology. It is explicitly concerned with the human context of the development of the individual with an emphasis on subjective meaning, a rejection of determinism, and a concern for positive growth rather than pathology. It posits an inherent human capacity to maximize potential, 'the self-actualizing tendency'. The task of Humanistic therapy is to create a relational environment where this tendency might flourish.
- Brief - "Brief therapy" is an umbrella term for a variety of approaches to psychotherapy. It differs from other schools of therapy in that it emphasizes (1) a focus on a specific problem and (2) direct intervention. It is solution-based rather than problem-oriented. It is less concerned with how a problem arose than with the current factors sustaining it and preventing change.
- Systemic - seeks to address people not at an individual level, as is often the focus of other forms of therapy, but as people in relationship, dealing with the interactions of groups, their patterns and dynamics (includes family therapy & marriage counseling).
- Transpersonal - Addresses the client in the context of a spiritual understanding of consciousness.

There are hundreds of psychotherapeutic approaches or schools of thought. By 1980 there were more than 250. By 1996 there were more than 450,. The development of new and hybrid approaches continues around the wide variety of theoretical backgrounds. Many practitioners use several approaches in their work and alter their approach based on client need.

General concerns

Psychotherapy can be seen as an interpersonal invitation offered by (often trained and regulated) psychotherapists to aid clients in reaching their full

potential or to cope better with problems of life. Psychotherapists usually receive remuneration in some form in return for their time and skills. This is one way in which the relationship can be distinguished from an altruistic offer of assistance.

Psychotherapists and counselors often require to create a therapeutic environment referred to as the frame, which is characterized by a free yet secure climate that enables the client to open up. The degree to which client feels related to the therapist may well depend on the methods and approaches used by the therapist or counselor.

Psychotherapy often includes techniques to increase awareness, for example, or to enable other choices of thought, feeling or action; to increase the sense of well-being and to better manage subjective discomfort or distress. Psychotherapy can be provided on a one-to-one basis or in group therapy. It can occur face to face, over the telephone, or, much less commonly, the Internet. Its time frame may be a matter of weeks or many years. Therapy may address specific forms of diagnosable mental illness, or everyday problems in managing or maintaining person relationships or meeting personal goals. Treatment of everyday problems is more often referred to as **counseling** (a distinction originally adopted by Carl Rogers) but the term is sometimes used interchangeably with "psychotherapy".

Psychotherapists employ a range of techniques to influence or persuade the client to adapt or change in the direction the client has chosen. These can be based on clear thinking about their options; experiential relationship building; dialogue, communication and adoption of behavior change strategies. Each is designed to improve the mental health of a client or patient, or to improve group relationships (as in a family). Most forms of psychotherapy use only spoken conversation, though some also use other forms of communication such as the written word, artwork, drama, narrative story, or therapeutic touch. Psychotherapy occurs within a structured encounter between a trained therapist and client(s). Because sensitive topics are often discussed during psychotherapy, therapists are expected, and usually legally bound, to respect client or patient confidentiality.

Psychotherapists are often trained, certified, and licensed, with a range of different certifications and licensing requirements depending on the jurisdiction. Psychotherapy may be undertaken by psychologists, counseling psychologists, social workers, marriage-family therapists, expressive therapists, trained nurses, psychiatrists, psychoanalysts, mental health counselors, school counselors, or professionals of other mental health disciplines. Psychiatrists have medical qualifications and may also administer prescription medication. The primary training of a psychiatrist focuses on the biological aspects of mental health conditions, with some training in psychotherapy. Psychologists have more training in psychological assessment and research

and, in addition, in-depth training in psychotherapy. Social workers have specialized training in linking patients to community and institutional resources, in addition to elements of psychological assessment and psychotherapy. Marriage-Family Therapists have specific training and experience working with relationships and family issues. A Licensed Professional Counselor (LPC) generally has special training in career, mental health, school, or rehabilitation counseling to include evaluation and assessments as well as psychotherapy. Many of the wide variety of training programs are multi-professional, that is, psychiatrists, psychologists, mental health nurses, and social workers may be found in the same training group. Consequently, specialized psychotherapeutic training in most countries requires a program of continuing education after the basic degree, or involves multiple certifications attached to one specific degree.

Specific schools and approaches

In practices of experienced psychotherapists, therapy will not represent pure types, but will draw aspects from a number of perspectives and schools.

Psychoanalysis

Psychoanalysis was developed in the late 1800s by Sigmund Freud. His therapy explores the dynamic workings of a mind understood to consist of three parts: the hedonistic *id* (German: *das Es*, "the it"), the rational *ego* (*das Ich*, "the I"), and the moral *superego* (*das Überich*, "the above-I"). Because the majority of these dynamics are said to occur outside people's awareness, Freudian psychoanalysis seeks to probe the unconscious by way of various techniques, including dream interpretation and free association. Freud maintained that the condition of the unconscious mind is profoundly influenced by childhood experiences. So, in addition to dealing with the defense mechanisms employed by an overburdened ego, his therapy addresses fixations and other issues by probing deeply into clients' youth.

Other psychodynamic theories and techniques have been developed and used by psychotherapists, psychologists, psychiatrists, personal growth facilitators, occupational therapists and social workers. Techniques for group therapy have also been developed. While behavior is often a target of the work, many approaches value working with feelings and thoughts. This is especially true of the psychodynamic schools of psychotherapy, which today include Jungian therapy and Psychodrama as well as the psychoanalytic schools. Other approaches focus on the link between the mind and body and try to access deeper levels of the psyche through manipulation of the physical body which gave rise to various *body movement* based psychotherapeutic approaches such as neo-Reichian Alexander Lowen's Bioenergetic analysis, Peter Levine's Somatic Experiencing, Jack Rosenberg's integrative body psychotherapy, Pat Ogden's sensorimotor psychotherapy etc. They are not to be confused with

alternative medicine body-work which seeks primarily to improve physical health because despite the fact that bodywork techniques (for example Alexander Technique, Rolfing, and the Feldenkrais Method) affect the emotions, they are not overtly designed to work on psychological issues.]

Gestalt Therapy

Gestalt Therapy is a major overhaul of psychoanalysis. In its early development it was called "concentration therapy" by its founders, Frederick and Laura Perls. However, its mix of theoretical influences became most organized around the work of the gestalt psychologists; thus, by the time 'Gestalt Therapy, Excitement and Growth in the Human Personality' (Perls, Hefferline, and Goodman) was written, the approach became known as "Gestalt Therapy."

Gestalt Therapy stands on top of essentially four load bearing theoretical walls: phenomenological method, dialogical relationship, field-theoretical strategies, and experimental freedom. Some have considered it an existential phenomenology while others have described it as a phenomenological behaviorism. Gestalt therapy is a humanistic, holistic, and experiential approach that does not rely on talking alone, but facilitates awareness in the various contexts of life by moving from talking about situations relatively remote to action and direct, current experience.

Group Psychotherapy

The therapeutic use of groups in modern clinical practice can be traced to the early years of the 20th century, when the American chest physician Pratt, working in Boston, described forming 'classes' of fifteen to twenty patients with tuberculosis who had been rejected for sanatorium treatment. The term group therapy, however, was first used around 1920 by Jacob L. Moreno, whose main contribution was the development of psychodrama, in which groups were used as both cast and audience for the exploration of individual problems by reenactment under the direction of the leader. The more analytic and exploratory use of groups in both hospital and out-patient settings was pioneered by a few European psychoanalysts who emigrated to the USA, such as Paul Schilder, who treated severely neurotic and mildly psychotic out-patients in small groups at Bellevue Hospital, New York. The power of groups was most influentially demonstrated in Britain during the Second World War, when several psychoanalysts and psychiatrists proved the value of group methods for officer selection in the War Office Selection Boards. A chance to run an Army psychiatric unit on group lines was then given to several of these pioneers, notably Wilfred Bion and Rickman, followed by S. H. Foulkes, Main, and Bridger. The Northfield Hospital in Birmingham gave its name to what came to be called the two 'Northfield Experiments', which provided the impetus for the development since the war of both social therapy, that is, the

therapeutic community movement, and the use of small groups for the treatment of neurotic and personality disorders.

Medical and Non-Medical Models

A distinction can also be made between those psychotherapies that employ a medical model and those that employ a humanistic model. In the medical model the client is seen as unwell and the therapist employs their skill to help the client back to health. The extensive use of the DSM-IV, the diagnostic and statistical manual of mental disorders in the United States, is an example of a medically-exclusive model.

The humanistic model of non medical in contrast strives to depathologise the human condition. The therapist attempts to create a relational environment conducive to experiential learning and help build the client's confidence in their own natural process resulting in a deeper understanding of themselves. An example would be gestalt therapy.

Some psychodynamic practitioners distinguish between more uncovering and more supportive psychotherapy. Uncovering psychotherapy emphasizes facilitating the client's insight into the roots of their difficulties. The best-known example of an uncovering psychotherapy is classical psychoanalysis. Supportive psychotherapy by contrast stresses strengthening the client's defenses and often providing encouragement and advice. Depending on the client's personality, a more supportive or more uncovering approach may be optimal. Most psychotherapists use a combination of uncovering and supportive approaches.

Cognitive Behavioral Therapy

Cognitive behavioral therapy refers to a range of techniques which focus on the construction and re-construction of people's cognitions, emotions and behaviors. Generally in CBT the therapist, through a wide array of modalities, helps clients assess, recognize and deal with problematic and dysfunctional ways of thinking, emoting and behaving.

Behavior Therapy

Behavior therapy focuses on modifying overt behavior and helping clients to achieve goals. This approach is built on the principles of learning theory including operant and respondent conditioning, which makes up the area of applied behavior analysis or behavior modification. This approach includes acceptance and commitment therapy, functional analytic psychotherapy, and dialectical behavior therapy. Sometimes it is integrated with cognitive therapy to make cognitive behavior therapy. By nature, behavioral therapies are empirical (data-driven), contextual (focused on the environment and context),

functional (interested in the effect or consequence a behavior ultimately has), probabilistic (viewing behavior as statistically predictable), monistic (rejecting mind-body dualism and treating the person as a unit), and relational (analyzing bidirectional interactions).[10]

Expressive Therapy

Expressive therapy is a form of therapy that utilizes artistic expression as its core means of treating clients. Expressive therapists use the different disciplines of the creative arts as therapeutic interventions. This includes the modalities dance therapy, drama therapy, art therapy, music therapy, writing therapy, among others. Expressive therapists believe that often the most effective way of treating a client is through the expression of imagination in a creative work and integrating and processing what issues are raised in the act.

Narrative Therapy

Narrative therapy gives attention to each person's "dominant story" by means of therapeutic conversations, which also may involve exploring unhelpful ideas and how they came to prominence. Possible social and cultural influences may be explored if the client deems it helpful.

Integrative Psychotherapy

Integrative Psychotherapy represents an attempt to combine ideas and strategies from more than one theoretical approach. These approaches include mixing core beliefs and combining proven techniques. Forms of integrative psychotherapy include multimodal therapy, the transtheoretical model, cyclical psychodynamics, systematic treatment selection, cognitive analytic therapy, Internal Family Systems Model, multitheoretical psychotherapy and conceptual interaction. In practice, most experienced psychotherapists develop their own integrative approach over time.

Hypnotherapy

Hypnotherapy is therapy that is undertaken with a subject in hypnosis. Hypnotherapy is often applied in order to modify a subject's behavior, emotional content, and attitudes, as well as a wide range of conditions including dysfunctional habits, anxiety, stress-related illness, pain management, and personal development.

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Further reading

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