CHAPTER TWO

WOMEN WITH HIV/AIDS IN CONTEXT

2.1 INTRODUCTION

HIV/AIDS emerged in approximately 1980 as a disease mainly affecting homosexual men in the United States of America. However, a mere six years later, it was recognised as a global health problem of enormous importance for all people irrespective of gender, sexual orientation or ethnic group. With epidemic proportions, it had spread to all other continents and most countries worldwide (Jackson, 2002).

Sub-Saharan Africa is the epicentre of the HIV/AIDS pandemic. About 28 million people in sub-Saharan countries were estimated to have been infected by the end of 2001. Although there are signs that perhaps the HIV prevalence is waning in some countries in Africa, such as Uganda, it is burgeoning in others. Botswana and South Africa have by far the highest infection rates (Clark, 2002), with as many as one in three adults affected. A report issued by Women's International Network News (2001) indicates that between 6 million and 7.5 million South Africans could be infected with the HIV virus in the next ten years. Currently one in four women attending ante-natal clinics in South Africa is infected with HIV. This translates into about 10% of the entire population of the country. Harrison, Smit and Myer (2000) maintain that it is unlikely that an effective vaccine against HIV infection will be widely available in the next ten years and even less likely that a cure will be found in this time. HIV/AIDS has the potential to devastate human development (Jackson, 2002).

In Africa and South Africa, it is true to say that HIV/AIDS is overwhelmingly distributed by heterosexual transmission and furthermore it is also true that women and their children are this infection's most vulnerable targets. African women still live in a world where they are expected to be submissive to men and are not yet equipped to exert themselves in a world where men control. There is a growing global understanding that HIV/AIDS is

less about infection and more about social, economic and cultural factors (Urdang, 2001). Quintessentially, in Africa especially, it is about gender and gender relations. It is a gender issue because it is unacceptable for a women to say no to unwanted and unprotected sex. Cultural beliefs, practices and values run so deep that women are silenced and prevented from making this life-saving demand. Neither can women say yes to an expression of their own identities and sexuality. What this inability underscores, is the fact that gender relations are based on power (Urdang, 2001). It follows suit that women are ostracised, discriminated against and abused.

It is with these ideas in mind that the issue of women with HIV/AIDS, especially in the (South) African context, is reviewed in the existing literature. Although statistics are a thorny and problematic matter, a review of the statistics in context is offered in order to provide a disturbing perspective on the enormity that is HIV/AIDS. Furthermore, it is important to highlight the plight of women with HIV/AIDS in such a way that brings to light the relevant issues that are covered in the existing literature, some of which have been mentioned in the above-mentioned paragraph.

Secondly, because this literature review regarding women with HIV/AIDS in context will form part of a larger study that proposes an integrated psychotherapeutic intervention from a salutogenic paradigm, a review of this paradigm is covered in this study. It follows that a wide ranging sample of existing therapies will also be reviewed. In the light of the review of these issues, some conclusions are drawn and recommendations offered.

2.2 THE STATISTICAL CONTEXT

The human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) have become major public health problems in many African countries. Indications are that South Africa is also facing a crisis of enormous proportions in this regard. An estimated 28 to 30 million people in sub-Saharan countries were estimated to have HIV/AIDS by the end of 2001. Botswana and South Africa have by far the highest

infection rates, with as many as one in three adults affected (Clark, 2002). Until a decade ago, the HIV/AIDS problem was not given the attention it needed regarding its rapid spread in this country. In fact, the current statistics on the rate of infection are of such proportions that it could become necessary to declare a state of national emergency on HIV/AIDS (Togni, 1997).

Worldwide, HIV/AIDS has caused untold anguish and enormous social tragedy. The daunting statistics reveal that an estimated 50 million people are currently infected with this virus (UNAIDS, 2000). A reputable South African weekly newspaper quotes in their HIV/AIDS barometer, an estimated worldwide HIV infection of 48 510 625 people as on 12 September 2002 (Mail & Guardian, 12 September 2002). Lachman (1995) emphasises that reported numbers of HIV/AIDS cases tend to be biased as a result of under-diagnosis, under-reporting and delays in reporting. Yet UNAIDS (2000) report 2.6 million deaths from AIDS worldwide, with a further 5.6 million people currently infected. It is clear that HIV/AIDS is a global problem and not merely a national public health issue. At a meeting to commemorate World AIDS day in Paris on December 1, 1994 the Secretary General of the United Nations, Dr Boutros Boutros-Galli, stressed the need for the recognition of a planetary emergency and asked that global strategies be invoked to stop the spread of AIDS (Lachman, 1995). This global strategy for AIDS prevention incorporates the idea that no country will be able to stop HIV until it is stopped in all countries. According to Lachman (1995), the HIV/AIDS pandemic is now out of control, for its course through and within global society is not being affected in any substantial manner by the actions taken thus far at national or international level. The best opportunities for HIV control have already slipped from our grasp (Lachman, 1995). The wider global implications as evidenced in continents such as Africa, India, Thailand and elsewhere, are drawing attention at the World Health Organisation, which is forecasting 20 million deaths in the next ten years (Lachman, 1995).

Current estimates suggest that about two out of every three cases of HIV infections are in sub-Saharan Africa (UN Health & Mortality, 1999). This high prevalence of HIV has led to drastic mortality increases and threatens to wipe out the gains that have been made in

life expectancy at birth in many of these countries. UN Health & Mortality (1999) states that it is unfortunate that appropriate data necessary for studying the dynamics of the HIV and AIDS pandemic are often inadequate. Most of the existing data are from small-scale, facility-based or geographically limited studies. Typically, the results are not generalisable to the national level and there is a lack of standardisation regarding the clinical definition of AIDS (UN Health & Mortality, 1999). As a result, much of what is known about the HIV/AIDS epidemic in Africa is only based on models.

A review of the available information on the prevalence rates of HIV infection indicates that sub-Saharan Africa has the highest rates in the world. By the beginning of 1997, about 22.6 million people world-wide either had contracted HIV infection or had AIDS, about 14 million (63 percent) of whom were sub-Saharan Africa (UN Health & Mortality, 1999). By the end of 1997, the Joint United Nations Program on HIV/AIDS (UNAIDS), had adjusted the global HIV/AIDS estimates upwards to 30.6 million (UN Health & Mortality, 1999). Their estimates put about 21.8 million of the HIV/AIDS in sub-Saharan Africa. The figures show that while the annual number of infections in sub-Saharan Africa relative to the world total seems to have reached a plateau in the 1990's, the cumulative total of estimated HIV infections is still rising in Africa (UN Health & Mortality, 1999). For example, the annual number of HIV infections estimated to be occurring in the region shows an inverted U-shaped curve relative to the world total. The proportion of the total HIV infections occurring annually in Africa is estimated to have increased from 67 percent in 1981 to a peak in of 79 percent in 1988 and then declined to 43 percent in 1995 (UN Health & Mortality, 1999). However, it must again be emphasised that lack of reliable data has been a major problem facing researchers seeking to understand the dynamics of HIV/AIDS in Africa.

Problems that have been identified in the existing data include nonrepresentativeness, geographic bias, testing bias and problems surrounding the clinical case definition of AIDS (UN Health & Mortality, 1999). Nonrepresentativeness is a problem because many studies of HIV prevalence in Africa are based on specially selected categories of respondents, making it difficult to generalise to the larger population. The overwhelming

majority of studies focus on pregnant women, patients attending STD clinics and prostitutes.

Geographic bias occurs because not only are sample sizes small and often unrepresentative, but an overwhelming majority of the existing seroprevalence studies in sub-Saharan Africa are based on samples taken from populations convenient for medical teams drawing blood for testing (Lachman, 1995). For this reason, many of the studies are facility-based, self-selected and mostly urban-based, therefore not representative of the general population. Use of convenient samples creates the likelihood of geographic bias, in which results represent people who are more accessible than those in less accessible areas of a country (UN Health & Mortality, 1999).

Testing bias relates especially to serologic tests that were done at the initial stages of the epidemic (UN Health & Mortality, 1999). It has been reported that testing techniques, especially the ELISA test, resulted in a number of false positives. Confirmatory testing by means of the Western Blot has improved over time.

A major source of bias that affects data from studies of AIDS in Africa is the use of different definitions of AIDS in different settings (Lachman, 1995). The procedure for AIDS identification in Africa is not uniform (UN Health & Mortality, 1999). Even the World Health Organisation's Bangui definition, which became standard for diagnosis, has been found to be inexact since organ systems can have similar responses to different pathogens and pathologies (Gilks, 1991).

The conclusion drawn is that pertinent and good quality data necessary for a thorough understanding of the HIV epidemic and for meaningful cross-national comparisons are inadequate in Africa. Standardisation of existing data is also urgently needed. Until this situation is rectified, the use of models will continue to shape beliefs about the HIV/AIDS epidemic in Africa and the policies implemented to deal with it (UN Health & Mortality, 1999).

As regards South Africa, there are numerous statistical sources, most only giving partial figures on a variety of facets of the HIV/AIDS challenge in this country. All attempts to acquire uniform national statistics have failed. The Department of National Health and Population Development confirm that no comprehensive statistics of HIV infections on a national level are kept. Only full-blown AIDS statistics are available and these cannot be trusted to reflect an accurate figure on the number of cases in the country (Togni, 1997). An example of this erratic statistical position is the figure indicating the number of HIV-positive people in South Africa by mid-1994. The figures supplied by different organisations range from 300 000 to 750 000 for the same period. A spokesperson from the Department of National Health suggested that in July 1994, 700 persons were being infected daily and that 7,5 percent of the adult population in the country were HIV-positive during the stipulated period (Togni, 1997).

Statistics can differ radically from source to source. Since AIDS is not a notifiable disease in South Africa, it is currently very difficult to make a realistic assessment of the actual status of the HIV/AIDS situation in the country. However, some form of reliable predictive statistics is needed in order to prepare for a possible pandemic within the life span of the majority of South Africans. Predictions made by Doyle (1993) are as reliable as possible, given the current statistical quandary. He suggests two scenarios for South Africa and his calculations were made on the basis of statistical information received from other African countries, based on the assumption that no changes in behavioural patterns would take place. This scenario he called SCEN60. The second scenario, SCEN61, was based on the assumption that significant changes of sexual behaviour took place during the 14 year period (1991 to 2005) covered by the projections. Doyle (1993) maintains that by 2005, a total of 7 153 000 people will be HIV-positive or have full-blown AIDS in terms of SCEN60, that is if prevailing attitudes and norms about sexual behaviour do not change. In terms of SCEN61, that is if attitudes do change, Doyle predicts a total of 5 380 000 people who will either be HIV-positive or have full-blown AIDS. He further predicts that in respect of SCEN60, there will be 2 588 000 cumulative deaths by the year 2005 and in respect of SCEN 61, an amount of 2 321 000 cumulative deaths for the same period.

The above projections are born out by the statistics provided by the South African Health Review (2000) which predicts that 1 500 people in South Africa are infected with HIV daily. The South African Health Review (2000) estimates that a total of 4.2 million people are living with HIV/AIDS in South Africa (South African Health Review, 2000). These figures correspond with those predictions made by Doyle. In fact Doyle (1993) predicts that by 2010, about 27 percent of the adult population of the country will be HIV-positive should sexual behaviour patterns remain unchanged. With South Africa having the largest percentage of people living with HIV/AIDS in the world (UNAIDS, 2000), these statistics reflect badly on the country's future and the resources of the nation will be taxed very heavily. Furthermore, these statistics cannot begin to encompass the depth of suffering and anguish that will face an enormous amount of people in this country.

At antenatal clinics throughout South Africa, statistics of HIV-positive women are being kept. Pregnant women have become a key group in the statistical assessment process of HIV/AIDS in South Africa. Togni (1997) refers to Dr Clive Evian of the Alexander Forbes Health Care, Sandton, who maintains that women in the age group 25-35 are considered a reasonably representative sample. Between September and October of each year since 1990, representative samples of blood from 15 000 pregnant women were tested anonymously. The results have been used as indicators of the HIV epidemic in South Africa. Predictions based upon these figures suggest that if extrapolated to the general population, as many as 20 million people could be HIV-positive as at the year 2000. However, the same arguments concerning inadequate data collection in sub-Saharan Africa in respect of HIV/AIDS statistics mentioned above, also applies to the South African situation. Should this represent anything near the actual prevalence of HIV/AIDS infection in South Africa, then the fears reflected in Lachman (1995), that HIV/AIDS is heavily under-reported and under-diagnosed, are possibly realised.

Togni (1997) quotes statistics released in 1996 by the Department of Health which indicate the prevalence of HIV amongst pregnant women who attended public health

facilities in the nine provinces of South Africa. These figures are relevant to the period 1994 and 1995. They illustrate the percentage increase in HIV infection, as well as the "doubling time", that is the number of years the current prevalence would be expected to double. These statistics reveal that the national epidemic increased by 39 percent from 1994 to 1995 and that it was likely to double again in the ensuing 30 months. The Gauteng data, which was likely to be the most accurate (Togni, 1997), indicated that the prevalence doubled in one year and although KwaZulu/Natal still had the highest prevalence in 1996, indications were that Gauteng would catch up in a matter of a few years. These statistics also indicated a very high prevalence amongst the 15-29 year age group amongst pregnant women (13,1%). The prevalence amongst teenage girls is 9,5 percent. The majority of pregnant women infected with the HIV virus are Black. Statistics quoted by Togni (1997) derived from a national HIV survey of women attending antenatal clinics in 1994, by Metropolitan Life, reveal that the rate of infection amongst White women was 0.6 percent compared to 4.9 percent Black women.

2.3 WOMEN WITH HIV/AIDS

It is only in the 1990's that the world started to recognize the special threat that HIV/AIDS poses to women. Yet attention to infection with HIV in women and their children still lags behind that being given to the disease in men (Heagarty, 1992). Little is currently known regarding the natural course of HIV infections in women and for example, there is little knowledge as to why there is a rapid progression of the disease when a woman becomes pregnant (Lachman, 1995). Now at the turn of the century, when the plight of women is viewed in the context of HIV/AIDS in Africa, evidence indicates that there are now more HIV infections in women than in men (UNAIDS, 2000). Fifty five percent of infected adults are women, translating into six HIV-positive women for every five HIV infected men. In 1998, 60% of new HIV infections were in young people aged 15 to 24 and in many countries girls in that age range were six times more likely to be infected than boys (Esu-Williams, 2000). In certain regions in Africa, adolescent women are as much as six times more likely than adolescent men to be infected. In some parts of Kenya and Zambia for instance, teenage women have HIV

prevalence rates of 25% compared with 4% among teenage men (Women's International Network News, 2002). In Botswana about one-third of women ages 15 to 24 are estimated to be HIV-positive, twice the proportion rate amongst men of the same age. Currently, about one in four women attending ante-natal clinics in South Africa is infected with HIV, which translates into about 10% of the entire population (Harrison, Smit & Myer, 2000). Women aged 20 to 30 years are the worst affected group in South Africa and the incidence of infection is highest in women between 15 and 30 years of age (Harrison, Smit & Myer, 2000).

Originally the virus was restricted mostly to male homosexuals, but increasingly the spread of the disease has changed quite drastically. On the African continent the spread of the HIV virus is predominantly through the heterosexual population (Togni, 1997). This immediately makes the role of the woman of the utmost importance. Women play a very important role in the family and in the community. They bear and raise children. Furthermore their gender and sexuality have become significant factors in the sexual transmission of the HIV virus (Gupta, 2001). The effects of the spread of this virus will place a great burden on women and their children and it is they who will probably suffer most in terms of social and economic deprivation (Togni, 1997). Women confronted with HIV infection will also have to deal with the emotional and sexual impact on the relationship with her partner, confront reproductive decisions and consequences, plan for the future of those children and confront the issue of disclosure to friends and family. Very often, this will have to take place without the support, emotionally and otherwise, of the male partner (VanDevanter, Thacker, Bass & Arnold, 1999).

Given that women clearly require all the protection they can use, there are many obstacles that stand in their way. Political, cultural and economic concerns, combined with historically powerful patterns of gender discrimination and neglect of women's sexuality, must be viewed as stumbling blocks to the development and distribution of methods that women can control (Susser & Stein, 2000). As women observe the deaths of family members, infants and neighbours infected with HIV/AIDS, their awareness of their own risk becomes more firmly internalized. This is particularly relevant with the

multitude of infants being born HIV-positive. Santmyire (2001) states that vertical transmission of HIV, that is transmission from mother to child, is a major factor in the increasing rates of HIV infection in sub-Saharan Africa. Vertical transmission occurs in utero, intrapartum during labour and delivery, and postpartum during breastfeeding (Santmyire, 2001). This may be the stimulus required for women to take action and search for steps to take, individually and collectively, to protect themselves and their community (Susser & Stein, 2000).

2.3.1 The Biological Context

Biology makes women anatomically and physiologically more vulnerable to contract HIV/AIDS than men. The risk of becoming infected with HIV during unprotected sex is two to four times greater for a woman than for a man (Women's International News Network, 2002). Male to female transmission is more likely because during vaginal intercourse a woman has a larger surface area of her genital tract exposed to her partner's sexual secretions than does a man. HIV concentration is generally higher in male semen than in a woman's sexual secretions (Women's International Network News, 2002).

Adolescent women are at even greater risk than adult women. The vagina and cervix of young women are less mature and are less resistant to HIV and STI's such as chlamydia and gonorrhea (Women's International Network News, 2002). Changes in the reproductive tract during puberty make the tissue more susceptible to penetration by HIV. Also, hormonal changes associated with the menstrual cycle often are accompanied by a thinning of the mucus plug, the protective sealant covering the cervix. Such thinning can allow HIV to pass more easily. Young women produce only scant vaginal secretions, providing little barrier to HIV transmission (Women's International Network News, 2002).

2.3.2 A Gender-Based Power Imbalance

Gender is not a synonym for sex. It refers to widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics and roles (Gupta, 2001). It is a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with one another. Gender is a culture-specific construct (Gupta, 2001). There are significant differences in what women and men can and cannot do in one culture as compared to another. Yet what is fairly consistent across cultures is that there is always a distinct difference between women's and men's roles, access to productive resources and decision-making authority. Typically men are seen as being responsible for the productive activities outside the home, while women are expected to be responsible for reproductive and productive activities inside the home (Gupta, 2001). Women have less access over and control of productive resources such as income, land credit and education, than men. Sexuality is distinct from gender yet intimately linked to it. It is the social construction of a biological drive (Gupta, 2001). An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances and with what outcomes.

The components of sexuality are known as the P's of sexuality – practices, partners, pleasure/pressure/pain and procreation. Data gathered over many years reveals an additional P of sexuality that is the most important of all – power (Esu-Williams, 2000). The power underlying any sexual interaction determines how all the P's of sexuality are expressed and experienced. Power determines whose pleasure is given priority and when, how and with whom sex takes place. Each component of sexuality is closely related to the other, but the balance of power in a sexual interaction determines its outcomes. Power is fundamental to both sexuality and gender (Gupta, 2001). The unequal power balance in gender relations that favours men, translates into an unequal power balance in

heterosexual interactions, in which male pleasure supercedes female pleasure and men have greater control than women over when, where and how sex takes place (Gupta, 2001).

This power imbalance that defines gender relations and sexual interactions, also affects women's access to and use of services and treatment (Women's International Network News, 2001). While men make the decision to seek voluntary counselling and testing independent of others, women feel compelled to discuss testing with their partners before accessing the service, thereby creating a potential barrier to accessing services. HIV-positive women bear a double burden. They are infected and they are women. In many societies, being socially ostracized, marginalized and even killed are very real potential consequences of exposing one's HIV status (Gupta, 2001). Yet HIV testing is critical for receiving treatment or for accessing drugs to prevent the transmission of HIV from a woman to her child.

2.3.3 The Socio-Cultural Context of Women

The odds against women and girls in Africa are great. African women still live largely in a world where they have to first and foremost prove their worth by being married, having children and caring for their families (Esu-Williams, 2000). They are not yet equipped to exert themselves in a world that men control. Therein lies their vulnerability to HIV/AIDS. Esu-Williams (2000) sounds the struggle to liberate women in Africa from the mentality with which they are conditioned to grow up, that their lives are less of a priority than those of their male partners. She states that women are not expected to initiate sexual intercourse with a spouse unless they want risk abuse or even violence. She goes on to say that within the social and cultural contexts, women affected by HIV/AIDS are often faced with no means to confront the denial of their basic rights, including the right to property, to their children and to produce the means

to their own livelihood. Women's economic dependence increases their vulnerability to HIV. The economic vulnerability of women makes it more likely that they will exchange sex for money or favours, less likely that they will succeed in negotiating protection and less likely that they will leave a relationship that they perceive to be risky (Gupta, 2001).

In many societies in the African context, there is a culture of silence that surrounds sex that dictates that "good" women are expected to be ignorant about sex and passive in sexual interactions (Gupta, 2001). This makes it difficult for women to be informed about risk reduction, or makes it difficult for them to be proactive in negotiating safer sex. With such expectations, women often feel powerless to protect themselves against HIV infection and unintended pregnancies. Often young girls endure sexual coercion and abuse (Women's International Network News, 2002) and in Kenya, 40% of sexually active female adolescents reported that their first intercourse was forced. In Cameroon, 40% of female adolescents reported that they had been forced or tricked into sex. Young women sometimes give in to having sex for fear that if they refuse, they will be raped anyway. Virginity also puts a young girl at risk of rape and sexual coercion because of the erroneous belief that sex with a virgin can cleanse a man of infection (Gupta, 2001).

Wife abuse is widespread (Women's International Network News, 2002). In some countries in Africa, more than 40% of women have been assaulted by their partners. In population-based studies, anywhere from 10- to over 50 percent of women report physical assault by an intimate partner. One third to one half of physically abused women also report sexual coercion. In Rwanda for example, HIV-positive women with an HIV-positive partner were more likely to report sexual coercion in their relationship, than were women without. In Tanzania, partner violence was ten times higher among young HIV-positive women than HIV-negative women (Women's International Network News, 2002). Violence

against women contributes both directly and indirectly to women's vulnerability to HIV (Gupta, 2001). Physical violence, the threat of physical violence and the fear of abandonment act as significant barriers for women who have to negotiate the use of a condom, discuss fidelity with their partners, or leave relationships that they perceive to be risky (Gupta, 2001).

In African cultures, including South Africa, the premium placed on having children often leads to childhood marriage and early childbearing (Women's International Network News, 2002). Girls, sometimes as young as ten years of age, are given to older men in marriage in order to cement friendships and economic ties between families. When girls are married to older men, they can be vulnerable to HIV infection because their husbands usually have already had a number of sexual partners. Social, political and religious barriers often hide young wives from the world, while their husbands frequently have other sexual partners.

Polygamy in sub-Saharan Africa is widely practiced, even though it exists on no other continent (Hosken, 2001). When the husband seeks a new, often younger wife, he may have sexual contact with a number of other women and thus bring HIV home. In some cultures in which South Africa in some tribes is included, wife inheritance is practiced – a tradition in which a wife is given to her brother-in-law upon her husband's death (Hosken, 2001). Either partner can be at risk of HIV infection if the other is infected. Younger widows are at particular risk because they are more likely to seek and be sought by other sex partners.

In some societies payment of bride price or "lobola" is required by the man to the father of the woman he wants to marry. Once the bride price is paid, the woman cannot leave her husband (Woman's International Network News, 2002). Even if

her husband's behaviour places her at risk of HIV infection, the woman may not be able to protect herself. She is literally "owned" by the husband.

Rites of passage from childhood to adulthood, although traditionally serving to unite communities, also increase the risk of HIV infection (Women's International Network News, 2002). For example, traditional male or female circumcisions and female genital mutilation are often carried out using the same unsterilised knives, thereby potentially infecting all participants. Hosken (2001) urgently calls for the outlawing of this and other offensive and degrading exploitation of women and for African men to change their behaviour towards women, including their "Traditions", if African society is to survive.

Research on HIV/AIDS stigma also reveals a gender paradox (Esu-Williams, 2000). HIV/AIDS is still associated with sexual misbehaviour and promiscuity. While it is almost universally acknowledged and accepted that men are much more likely to have had multiple sex partners, society's disapproval somehow ends up on the heads of women rather than men. HIV-positive women face stigmatization and are more likely than men to be blamed, stigmatized and abandoned by their families (Women's International Network News, 2001). Moreover, mothers tend to suffer blame and stigma when their infants or young adult children become HIV infected. Community stigma, along with lack of community education, poor communication between couples and lack of resources to care for motherless children, are exerting a powerful impact (Esu-Williams, 2000). Many women who are offered HIV tests in order to participate in programs that provide anti-retroviral drugs and free formula, refuse testing because of the dangers and difficulties they would face were they to test positive – partner rejection, stigma and psychological stress as a result of the diagnosis. Were there fewer stigmas associated with being HIV-positive and resources to care for the children when parents die, these women might feel more comfortable participating in these programs.

Esu-Williams (2000) maintains that for women in Africa, their strength has been and remains, in working together, teaching each other, sharing their experiences and supporting one another. Women so far, have been passive in sexual relationships, with little participation in decision-making or suggestions relating to their role in sexual activity. However, such traditionalist views hold little currency in the modern world, especially when sexual activity can lead to HIV infection and disastrous consequences for a woman and her children (Rhodes & Cusick, 2000). Enlightenment and liberation is essential for women, who in turn can play a vital role in persuading their partners to employ safer sexual practices aimed at reducing infection risk (Henderson, 1996). Yet the question is always relevant whether women are and/or can respond to entreaties to adopt safer sex practices. As long ago as 1995 the phrase "safer sex" was being questioned as dull and restrictive and thus not getting through (Lachman, 1995). It goes without saying that in cultures where women are in no position to negotiate safe sex and even those who are in a better position to do so, but for one reason or another do not consider it worthwhile, they are at an ever-increasing risk of HIV-infection.

2.3.4 The Political Context

It is important to also view HIV/AIDS within a political context and in this instance the South African political context. In the broader context of Africa, which includes widespread poverty and unemployment, particularly amongst women, a history of men crossing national boundaries in battles for independence or other military actions, social disasters and the increase in intra-Africa economic exchanges, which are based on colonial patterns of production reinforced by uneven regional investment in the global economy, is heavily incriminated in the spread of HIV/AIDS (Susser & Stein, 2000).

Grundlingh (2001) notes that in South Africa HIV/AIDS became known during the Apartheid political regime. He states that at first, HIV/AIDS was viewed as a homosexual disease, a disease of drug users and later on a disease of the Black communities. Therefore the history of HIV/AIDS in South Africa is rooted in a framework couched in a discourse of deviancy and scapegoats and thus there was no urgency in addressing this infection. It exposed and intensified social prejudices, stereotypes and economic inequalities, discriminatory practices and political injustices (Grundlingh, 2001).

In addition, the involuntary migration associated with men's employment far away from home, which was enforced by the previous Apartheid regime and which was experienced by many families in rural and semi-rural areas, is associated almost inevitably with casual and extra-marital sexual encounters (Susser & Stein, 2000). As a result of these factors, extra-marital sex is frequent amongst men and widely tolerated, if not necessarily enjoyed, by women.

Like so many other infectious diseases, HIV/AIDS is a disease of poverty and South Africa's history of inequity and social dislocation must have contributed to the severity of the epidemic. HIV/AIDS prevention programs cannot address these broader complexities directly, but they must take cognizance of this context within which the infection is spread (Harrison, Smit & Myer, 2000).

Under the current government, the official ANC policy on HIV/AIDS in South Africa is clouded by controversy. This is fuelled in particular by President Mbeki's public flirtations with dissident theories that refute the fact that HIV causes AIDS. He and his cabinet tend towards blaming AIDS on poverty and the Apartheid legacy. Despite the excellent report issued in 2001/2002 by the Medical Research Council (http://www.mrc.ac.za/annualreport/health.htm), which emphasises the growing threat of HIV/AIDS, the ANC government seems to be in

denial (http://www.da.org.za). They intentionally held back this report whilst claiming that HIV/AIDS was not such a serious problem. On top of the storm caused by President Mbeki's dissident comments, he has also come under fire for underplaying the AIDS crisis, questioning whether the spending priorities of the South African Health Department correspond with statistics issued by the World Health Organisation. The statistics he was referring to were outdated six year old 1995 statistics that ranked AIDS as only twelfth on a list of leading causes of death in South Africa (http://www.iafrica.com/pls/cms/iac). In a letter to Health Minister Manto Tshabalala-Msimang, he questioned the seriousness of HIV/AIDS and questioned whether it was receiving too much funding. As a result, ex-President Nelson Mandela publicly rapped President Mbeki over the knuckles for his approach on HIV/AIDS (http://evilanc.tripod.com/index/id9.html). Furthermore, the ANC government has refused to offer free anti-retroviral drugs to the South African public, especially the AZT drug for AIDS-infected (pregnant) mothers.

The formation of the Presidential AIDS Advisory Council appears to be little more than a talk-shop, as almost a year after its inception, nothing except an interim report which revealed nothing new, has been forthcoming. The Minister of Health has on several occasions misled Parliament and the South African public by denying the existence of substantial offers by the pharmaceutical industry for cheaper anti-retrovirals (ARV's). It is still ANC policy not to use ARV's, except for a few 'pilot sites' in preventing vertical mother to child transmission (http://www.da.org.za).

In reality, it appears as if the ANC policy on AIDS is nonsensical, disjointed and without definitive leadership. Under the misguided dissident views of the President, the government has argued against the use of AIDS drugs such as Nevirapine, stating that they are too expensive and potentially dangerous. The government was finally forced to dispense the drug Nevirapine as a result of a

series of court rulings. In a major policy shift in April 2002, the South African government said it will provide free AIDS drugs and counselling to victims of sexual assault, as well as to pregnant HIV infected women (http://www.africaonline.com).

2.3.5 The Psychological Context

The problems associated with HIV/AIDS transcend the medical diagnosis and treatment of the infection. HIV/AIDS will not only impact upon the biomedical field, but will also significantly affect the psychological and social realities of any person touched by the virus. Therefore, the health and sense of well-being of individuals affected by HIV/AIDS are not dependent solely on the achievements of biomedicine. The psychological reaction to the diagnosis is the initial influence that knowledge of HIV infection has on the individual's life. The shock and turmoil resulting from a diagnosis of HIV infection is understandable and usually responds to sensitive, informed psychotherapy and counselling (Jordaan, 1995).

Many of the issues particular to HIV infection have a bearing on the psychological health of the individual infected. These include stereotyping and marginalisation, which research demonstrates is quite prevalent amongst African women. HIV/AIDS is still associated with sexual misbehaviour and promiscuity, and society's disapproval, especially in the African context, ends up on the head's of women and they bear the brunt of the blame (Esu-Williams, 2000; Gupta, 2001; Women's International Network News, 2001; Buseh, Glass & McElmurry, 2001). Other issues may include reaction to the terminal nature of the infection, prolonged adjustment reactions, anxiety, obsessions, feelings of anger and guilt, social stigmatisation and interpersonal problems (Jordaan, 1995).

In reflecting upon the psychological context of women with HIV/AIDS, it becomes clear that there is a dearth of specific research in this particular area. Most of the literature, particularly that focused on Africa and South Africa, addresses mainly the socio-cultural and even the political implications of HIV/AIDS in respect of women. For example, Buseh, Glass and McElmurry (2001) state that focus group findings reveal gender, social, economic and societal factors related to HIV/AIDS transmission and prevention in an analysis of the infection in rural Swaziland. No mention is made of any psychological factors or implications thereof. As a result, it becomes necessary to look at the universal literature regarding the psychological context of HIV/AIDS with the assumption that in many ways it may generalise to all people, including women(in Africa).

Research suggests that the most typical psychological outcome that people with HIV infection face is depression. Hedge (1990) notes a high prevalence (40-60%) of individuals infected with HIV showing depressive symptomatology, with depression being more prevalent in females, the unemployed and those with increasing severity of physical symptoms. Hedge suggests that depression may also have a direct effect upon the immune system, using the CD4 count as a marker of immune functioning with depressed and non-depressed HIV seropositive individuals matched for age and CD4 count. For a period of over five years, researchers found a steeper decrease in CD4 count in those who showed symptoms of depression, thereby suggesting that depression is a possible contributor to immune suppression (Hedge, 1990). Depression may result from a variety of factors; feelings of lack of control over one's fate, changes in a person's self image - from being healthy to being sick, worry over the implications of the illness on personal relationships and circumstances, exposure to stigma and possible resulting abuse, and the perceived and real (in the context of African women) risks of disclosure. Stigmatisation may lead to a very real lack of social support, resulting in isolation, which in turn may lead to depression and anxiety (Wright & Coyle, 1996). Silversides (1998) refers to Cornell University

psychiatrist John Markowitz, who states that depression tends to be under-treated in people who are HIV-positive. An individual who has had little prior experience with a serious health problem, may lack schema or interpretive frames from which to interpret and/or predict illness-related events, that is unfamiliar symptoms (Brashers, et al., 1999). Uncertainty in illness, where individuals with chronic illnesses like HIV/AIDS, experience uncertainty about ambiguous symptoms, complex systems of treatment and care, insufficient information about diagnosis and progression, may evidence strong symptoms of depression and anxiety. This may be particularly true of women in Africa who do not have the benefit of first world medical and counselling facilities. Studies of HIV-related uncertainty have shown that uncertainty is negatively associated with quality of life and psychological adjustment (Brashers, et al., 1999).

Research has drawn attention to the frequency of suicide and suicidal tendencies and it is recognized that completed suicide is more common than previously estimated (Hedge, 1990; Jordaan, 1995). The frequency of suicidal behaviours and thoughts within an HIV infected population was compared to rates with that of alcoholics, whose risk is 9-22 times higher than that of the general population. Research found no significant difference in suicidal thoughts or behaviours between these groups, which suggests that the HIV infected population as high risk with regard to suicidality (Hedge, 1990). Avoidance coping strategies and deprivation from social support was associated with suicidal behaviours. Jordaan (1995) states that the relative risk for suicide in men with HIV/AIDS aged 20-59 years, is 39 times that of men of this age without diagnosis, and 66 times that of the general population. Although higher rates of suicide also occur in other chronic and life-threatening diseases such as cancer, problems for HIV/AIDS individuals such as stigmatization, possible withdrawal of the support of family and friends and fears of disfigurement, appear to contribute towards the suicidal impulse (Jordaan, 1995).

HIV infected individuals also frequently experience anxiety due to the uncertain prognosis and course of the illness, as well as the threat of death implied by this infection (Sikkema, et al., 2000). The effects of medication (if available), the status of the infected person's partner and the partner's ability to cope with the situation are notable contributing factors to the incidence of anxiety in people infected with HIV/AIDS. In the case of (South) African women, concern over their children and other dependents may contribute significantly towards the incidence of anxiety, as well as the implied threat contained in self-disclosure and possible societal ostracisation.

In a study on the relative impact of HIV/AIDS on thirty seven women's lives who were HIV-positive and who lived in a First World setting, Ciambrone (2001) found that this sample of women did not consider HIV to be the most devastating event in their lives. Rather, violence, mother-child separation and drug use were deemed to be more disruptive than HIV infection. Several factors, including race, drug use and abuse histories, social support and diagnosis, were central to women's differential assessment of HIV in relation to other disruptive events (Ciambrone, 2001). From this study it would seem that HIV by itself was not totally devastating, but seen in the context of it's social, economic and family consequences and knock-on effects, it could be very debilitating.

2.4 THE SALUTOGENIC PERSPECTIVE

In an article on positive psychology, Martin Seligman states that psychology after World War II became a science largely devoted to healing (Snyder & Lopez, 2002). It concentrated on repairing damage using a disease model of human functioning. This virtually exclusive attention to pathology neglected the idea of a fulfilled individual and a thriving community. He maintains that it also neglected the possibility that building strength is the most potent weapon in the arsenal of therapy (Snyder & Lopez, 2002).

Following this, the aim of positive psychology is to catalyse a change in psychology from a preoccupation with repairing the worst things in life, to also building the best things in life. This includes bringing the building of strength to the forefront in the treatment and prevention of mental illness.

Seligman states that the field of positive psychology at the subjective level, is all about positive subjective experience: well-being and satisfaction (past); flow, joy, sensual pleasures and happiness (present); constructive cognitions about the future such as optimism, hope and faith (Snyder & Lopez, 2002). At the individual level it is about positive personal traits such as the capacity for love and vocation, courage, interpersonal skill, aesthetic sensibility, perseverance, forgiveness, originality, future-mindedness, high talent and wisdom.

Continuing with his discussion on positive psychology Seligman states that before World War II, psychology had three distinct missions. They were to cure mental illness, make the lives of all people more productive and fulfilling, and identifying and nurturing high talent (Snyder & Lopez, 2002). Right after the war two events changed the face of psychology. They were the founding of the Veterans Administration in 1946, where thousands of psychologists in America discovered that they could make a living out of treating mental illness. The second was the founding of the National Institute of Mental Health in 1947 in America and academics found that they could get grants if their research was about pathology.

These two events had many benefits in respect of the first mission of psychology, the understanding and therapy for mental illness. However Seligman offers the downside to this, in that the other two missions of psychology were all but forgotten. Psychology saw human beings as passive foci. Stimuli came on and elicited responses. External reinforcements weakened or strengthened responses, drives and instincts. Conflicts from childhood pushed many people around (Snyder & Lopez, 2002).

Seligman goes on to state that psychology's empirical focus then shifted towards assessing and curing individual suffering (Snyder & Lopez, 2002). There occurred an explosion in research on psychological disorders and the negative effects of environmental stressors such as parental divorce, death, physical and sexual abuse. Practitioners of psychology went about treating mental illness within the disease-patient framework of repairing damage. The message of positive psychology says Seligman (Snyder & Lopez, 2002), is to remind the field of psychology that it has been deformed. It is not just the study of disease, weakness and damage, but also the study of strength and virtue. Positive psychology proclaims that there are human strengths that act as buffers against mental illness and psychopathology.

Seligman goes on to say that the major psychological theories now under gird a new science of strength and resilience (Snyder & Lopez, 2002). No longer do the dominant theories view the individual as something passive responding to stimuli. Rather, individuals are now seen as decision makers with choices, preferences and the possibility of becoming masterful, effectual, or, in malignant circumstances, helpless and hopeless. Science and practice that relies on the positive psychology worldview may have the direct effect of preventing many of the major emotional disorders (Snyder & Lopez, 2002). It is through the perspective of these lenses that is positive psychology that the salutogenic paradigm may be viewed.

It is also through these lenses of positive psychology and more specifically the salutogenic paradigm, that women in (South) Africa are viewed in the context of their vulnerability and susceptibility towards contracting HIV/AIDS, and their coping and resilience once infected. This application will be developed in further doctoral studies and the resultant thesis that will follow. However, it is important to note that the salutogenic perspective is being reviewed as a basis for the development of an integrated psychotherapeutic intervention founded upon this perspective and these principles.

2.4.1 The Salutogenic Paradigm

The term "paradigm" was introduced into philosophy of science in 1962 by Kuhn to describe a set of beliefs so fundamental that they are immune from empirical testing (Strumpfer, 1990). According to this view a paradigm characterises long periods of calm during which "normal science" is practised by the scientific community working to broaden and deepen the explanatory scope of a theoretical account based on a single set of fundamental beliefs. Although Kuhn considered it an open question what parts of social science have yet acquired paradigms in the strict sense in which he used the term, the concept of "paradigm", according to Strumpfer (1990), has entered the language of the social sciences to the extent that it is safe to use it in that context.

Psychology has been functioning mainly in a paradigm of pathogenic thinking (Strumpfer, 1990). It is such a deep-flowing *Glaubestrom* (current of belief), that many psychologists are at a loss to define "health" when not allowed to define it as absence of illness. Strumpfer (1990) states that in contrast thereto, a new paradigm is strongly in the ascent. This paradigm emphasises the origins of health, or wellness, and is called "salutogenesis". The word itself originates from the Latin, where *salus* means health, and the Greek, where *genesis* means origins.

There are a number of constructs that have been developed independently, but which seem to clearly be a part of this new paradigm. These are Antonovsky's "sense of coherence", Kobasa's "personality hardiness", Ben-Sira's "potency", Thomas's and Colerick's "stamina" and Rosenbaum's "learned resourcefulness" (Strumpfer, 1990). There are also other salutogenesis-related constructs such as Rotter's internal-external locus of control, de Charms' "personal causation", Kohn's and Schooler's "self-directedness", Bandura's "self-efficacy and human

agency" Crandall's "social interest" and Lefcourt's and Martin's "sense of humour" (Strumpfer, 1990). All of them deal with how people manage stress and stay well. All of them are of significance to psychology in general and are of fundamental importance for research and the practice of clinical, counselling and health psychology. However, it is Aaron Antonovsky, who according to Strumpfer (1990), is the clearest proponent of the paradigm of salutogenesis.

In 1970, a very concrete experience occurred which led to the fundamental turning point in Antonovsky's work as a medical sociologist and set him on the road to formulating what he came to call the salutogenic model (Antonovsky, 1987). He was in the midst of analysing the data in a study of adaptation to climacterium of women in different ethnic groups in Israel. One of those groups consisted of women born in central Europe between 1914 and 1923, who were therefore, between the ages of sixteen and twenty five in 1939. In the survey they had to answer a yes/no question about having been in the concentration camps during World War II, thereby creating a table comparing the emotional health ratings of a group of concentration camp survivors to those of a control group. Looking at the percentages of unimpaired women, he found that 51 percent of the control group women, compared to 29 percent of the survivors were in quite good overall emotional health. Antonovsky focused not on the fact that 51 is far greater than 29, but rather considered what it meant that 29 percent of a group of concentration camp survivors were judged to be in reasonable mental health. They had gone through the most unimaginable horror of the camps, followed by years of being displaced people and then had to re-establish their lives in a country (Israel), which witnessed three wars, and still be in reasonable mental health (Antonovsky, 1987). This led to his point of departure which was grounded in the data which indicated that at any one time, at least one third and quite possibly a majority of any population of any modern industrial society is characterised by some morbid, pathological condition. His conclusion was that illness is not a relatively rare deviance. A pathological orientation seeks to

explain why people get sick. By contrast, Antonovsky claimed that a salutogenic orientation, which focuses on the origins of health, poses a radically different question. It asked why are people located towards the positive end of the health ease/disease continuum, or why do they move towards this end, whatever their location at any given time (Antonovsky, 1987)? Thinking salutogenically, one has to do away with the dichotomy of people either being diseased or healthy, in favour of what Antonovsky called the health ease/dis-ease continuum (1987). All people fall somewhere between two theoretical poles of total terminal illness and total wellness.

The pathogenic orientation is generally directed at finding out why people fall ill and specifically at why they develop specific disease entities (Strumpfer, 1990). Such understanding is then used to find ways of combating and preventing each of the diseases in turn. "At the heart of the pathogenic paradigm is the assumption that diseases are caused by physical, biochemical, microbiological and psychosocial agents. In more sophisticated, present-day form, the emphasis is on multifactorial determination, usually in terms of risk factors". (Strumpfer, 1990, p.266). Essential to the pathogenic paradigm, is the concept of homeostasis. It implies that the normal state of the human organism is a relatively constant condition, which may vary somewhat, but is maintained by various interacting regulatory mechanisms (Strumpfer, 1990). However, homeostasis may be disrupted by pathogens and stressors. If the regulatory mechanisms do not function adequately, then disease sets in.

Acceptance of the salutogenic view does not imply rejection of the pathogenic orientation. The benefits of the pathogenic model are visible in all clinical fields and it is important that research continues to be directed towards the discovery of pathogens and the effects of stressors (Strumpfer, 1990). The pathogenic and salutogenic paradigms do different things and in many respects they compliment one another. According to Strumpfer (1990) though, they should not have too

peaceful a co-existence either, since the pathogenic paradigm is so preponderant and commanding that it is necessary to assert the salutogenic approach with might. It holds new insights and growth in the social sciences, and promise for integration of knowledge at a new, higher level (Strumpfer, 1990).

Looking at women with HIV/AIDS in context, it is with this salutogenic orientation in mind, that the alternative of seeking to do away with the dichotomy of either being diseased or healthy becomes important. The physical, biochemical and microbiological agents, although important in their own right, are counterbalanced by the potential for coping, resilience in the face of stressors and a focus on the active adaptation to a stressor-rich environment. It is the acknowledgement that so many women in sub-Saharan Africa who are so vulnerable for many reasons and factors regarding HIV/AIDS, yet seem to cope, and cope well.

2.4.2 Six Aspects of Salutogenesis

In order to elaborate more considerably on what salutogenesis actually is, it is important to consider six aspects of this orientation which were raised by Antonovsky (1987).

The first aspect has to do with the fact that by and large, the health-orientated emphasis, as well as the traditional medical disease orientated model, is based upon the perception that a fundamental dichotomy exists between healthy and sick people (Antonovsky, 1987). The former would allocate funding and attention to keeping people healthy, thereby preventing them from becoming sick. The latter focus upon treating those who are sick and seek to prevent disease and death. According to Antonovsky (1987), what both positions tend to disregard is

that the shared underlying dichotomous premise is a less powerful way of looking at matters than the health ease/dis-ease continuum. All people fall somewhere between the two theoretical poles of total terminal illness and total health or wellness. There are two truths. All people are terminal cases and in all people there is some measure of health. The salutogenic orientation proposes that the location of each person be studied on that continuum at any given time. In this way the emphasis shifts from samples of people who demonstrate particular forms of disease, to the whole population that becomes the subject to study (Strumpfer, 1990). In this way, women who are infected with HIV/AIDS are not diagnosed in terms of the dichotomous basis of being healthy or sick and the resultant labelling, anxiety and fear. They are able to consider sources of strength and health in their given scenario of infection that will enhance constructive cognitions, sense of well-being, courage, future-mindedness and positive meaning-making.

The second aspect of salutogenesis is that of focus. Researchers and practitioners often fall into the trap of focusing solely on the aetiology of the given disease, rather than always searching for the whole story of a human being including his/her sickness (Antonovsky, 1987). This means that to be blind to the suffering of the person, to the total life situation, is not only inhumane but also leads to an impoverished understanding of the person's state of health. Furthermore, the pathogenicist is restricted to remaining a narrow specialist in one particular disease, rather than gaining a more complete understanding of the dis-ease and the health ease of people. To compound matters, there is little or no structured communication between, for example, the cancer expert and the coronary expert. The concern here, is not that the clinician from a pathogenic orientation is less compassionate than the clinician from a salutogenic orientation, but that the former will miss a great deal of aetiological significance that becomes available to the latter who investigates the "story" (Antonovsky, 1987). The salutogenic approach does not guarantee problem solution of the complex circularities of

people's lives, but it leads to a more profound understanding and knowledge which is a prerequisite for moving towards the healthy end of the continuum.

The third important aspect of salutogenesis have to do with salutary and risk factors. "The pathogenic orientation is committed to the proposition that diseases are caused by bugs – microbiological, psychosocial, chemical, or what have you – singly, as in the germ theory, or multifactorially, as the more sophisticated have it" (Antonovsky, 1987, p.5-6). By contrast, the salutogenic orientation compels one to think in terms of the factors that promote movement towards the healthy end of the continuum. These are often different factors, not necessarily only low on certain risk factors. Instead of asking what causes a person to fall prey to a given disease – that is, focusing upon stressors – the question is rather asked what are the factors involved in at least maintaining one's position on the continuum or even moving towards the healthy pole.

The fourth aspect is the fact that the salutogenic model rejects the commonly held belief that that stressors are inherently bad (Strumpfer, 1990). The pathogenic orientation inevitably sees stressors as pathogenic, as risk factors, against which the person can be inoculated against or buffered. Thinking pathogenically, one conducts studies and designs experiments testing hypotheses that stressors are pathogenic. However, salutogenic thinking allows for studying the consequences of demands made on the organism to which there are no automatic adaptive or readily available resources, when there is good theoretical reason to predict positive health consequences (Antonovsky, 1987). The stressor, the disturber of the homeostasis, is seen as bad. On the other hand, salutogenesis opens the way for "the rehabilitation of stressors in human life" (Antonovsky, 1987, p.8). This implies that stressors as such, must be neutral in their health consequences. The consequences depend upon the person's response to the stressor (Strumpfer, 1990). The stressor arouses a condition of tension in the person and if the tension is managed poorly, stress occurs and the way is open for disease to occur. Yet if

managed well, the stressor may remain neutral or even become health enhancing (Strumpfer, 1990). In contrast to the pathogenic question of how the stressor can be neutralised or even eradicated, the salutogenic question asks how we can learn to live and live well, with stressors, and possibly even turn their existence to our advantage.

The fifth aspect of salutogenesis once again focuses on the question of aetiology and diagnosis. Salutogenesis compels one to look at people on a continuum, rather than the germs that cause a particular disease, and by doing so, one can arrive at a better diagnosis. The pathogenic orientation leads practitioners and researchers to concentrate on the particular disease diagnosed. "The ambiance that comes into being is that which Dubos (1960) so cogently warned against, 'the mirage of health.'" (Antonovsky, 1987, p.9). Salutogenesis leads to a focus on the overall problem of active adaptation to an inevitably stressor-rich environment. The key term, according to Antonovsky (1987), is negative entropy, which leads to a search for useful inputs into the social system, the physical environment, the organism and lower order systems down to the cellular level, to counteract the trend towards entropy. In other words, when "…one searches for cures for particular diseases, one tends to stay within the confines of psychopathology. When one searches for effective adaptation of the organism, one can move beyond post-Cartesian dualism and look to imagination, love play, meaning, will and the social structures that foster them" (Antonovsky, 1987, p.9), which are the theories of successful coping.

The sixth and final aspect of salutogenesis is that of the deviant case. Antonovsky (1987) pointed out that when a hypothesis about the relationship between a pathogen or a stressor and given conditions such as smoking and lung cancer for example, has been confirmed, still only part of the variance is accounted for. The pathogenecist is content with the hypothesis confirmation. The salutogenecist, without discounting what has been learned through the hypothesis confirmation,

looks at the deviant case (Antonovsky, 1987). Who are the smokers who do not get lung cancer, or the Type A persons who do not develop heart disease? The deviant case is the one who makes it against the odds.

Antonovsky (1987, p.13) summed up the most important consequence of the salutogenic orientation in one sentence: "Thinking salutogenically not only opens the way for, but compels us to devote our energies to, the formulation and advance of a theory of coping."

In the unfolding of the salutogenic orientation, it is important to follow Antonovsky to his formulation of the concept of sense of coherence and generalised resistance resources as another elements of this model.

2.4.3 General Resistance Resources

Strumpfer (1990) acknowledges that it was Antonovsky who introduced the concept of generalised resistance resources (GRR's) that can facilitate effective tension management in any situation of demand. The idea of GRR's does not deny the importance of specific resistance resources such as a particular drug for a specific disease for example. Antonovsky (1979) describes a range of such GRR's to include the following:

- *physical and biochemical GRR'S* such as immunosuppressors and potentiators
- *artefactual-material GRR's* and in particular wealth that can purchase food, clothing, power, status and services

- *cognitive GRR's* including knowledge-intelligence, education which does not only include skills, but also knowledge for example about avoiding HIV/AIDS, or of one's legal rights
- *the emotional GRR* of emotional identity
- *coping strategies* as overall plans of action for overcoming stressors
- *interpersonal-relational GRR's* like social support and commitment
- *macrosociocultural GRR's* of ready answers provided by a person's culture, social structure and religion

According to Antonovsky (1987), the commonality shared by all GRR's is that they make sense out of the countless stressors with which people are constantly bombarded. However, over repeated experiences of sense-making, a person develops over time, a strong "sense of coherence", the central construct of Antonovsky's salutogenic model (Strumpfer, 1990).

In the context of women in sub-Saharan Africa infected with HIV/AIDS, some GRR's could be the fact that women tend to support one another. "For women in Africa our strength has been, and remains, in working together, teaching each other, sharing our experiences, and supporting one another" (Esu-Williams, 2000, p.2). This interpersonal-relational GRR is one where women can support one another, talk and discuss, even cry together in cathartic, emotional bonding. In all of this may emerge a coping strategy and plan of action for overcoming (or partly overcoming) stressors. It may also be that in the spiritually rich environment of Africa, that the factor of religion (Du Plessis, 1997) plays a powerful role as a GRR. The meanings around religion and faith, the belief in a higher entity or power and the messages of redemption and liberation, are all very effective in terms of tension management in this specific situation of demand. They offer a perspective that allows for very real and explicit coping.

2.4.4 The Sense of Coherence Concept

"The sense of coherence is a very major determinant of maintaining one's position on the health ease/dis-ease continuum and of movement toward the healthy end" (Antonovsky, 1987, p.15). When initially defining the sense of coherence (SOC), Antonovsky (1979) highlighted its essentially cognitive nature and influenced by information theory, divided the perception of stimuli into seeing them as information or noise. He wrote of ways of seeing the world in a way that was predictable and comprehensible. In a series of in-depth and unstructured interviews with a wide variety of persons, he found that they all had two things in common. They had all experienced major trauma and they were all reported to be coping amazingly well (Antonovsky, 1987). The question that guided the interviews was how they saw their lives and an analysis of the protocols led to sixteen having a strong SOC and eleven being at the other end of the scale. Antonovsky then searched the protocols of these two extreme groups, looking for themes consistently found in one group and markedly absent in the other, and repeatedly was able to identify three such themes which he saw as the three core components of the SOC. These core components he called comprehensibility, manageability and meaningfulness (Antonovsky, 1987). The persons he had identified as having a strong SOC were high on these components, in stark contrast to those who were identified as having a weak SOC.

2.4.4.1 Comprehensibility

Comprehensibility refers to the extent to which one perceives the stimuli that confronts one, deriving from the internal and external environments, as making cognitive sense, as information that is ordered, consistent, structured and clear, rather than cluttered, chaotic, random and

inexplicable (Antonovsky, 1987). The person high on the sense of comprehensibility anticipates that stimuli to be encountered, will be predictable, or when they come as surprises, will be ordered and explicable. It means that the perceptions make cognitive sense and a solid capacity to judge reality.

2.4.4.2 Manageability

Antonovsky (1987) defines manageability as the extent to which one perceives that resources are at one's disposal which are adequate to meet the demands posed by the stimuli that bombard one. This may mean resources under one's own control, or controlled by legitimate others such as a spouse, friends, God, - someone who is felt can be counted upon and in whom one trusts. Strumpfer (1990) makes the point that the mere perception that help is available may operate without any support actually being provided. If one has a high sense of manageability states Antonovsky (1987), one will not feel victimised by events or feel that life is treating one unfairly. If and when untoward things happen, one will be able to cope and not grieve continuously.

2.4.4.3 Meaningfulness

Antonovsky (1987) sees this component of the SOC as representing the motivational element. In the interview protocols written of above, those being interviewed who were classified as having a strong SOC, always spoke of areas of life that were important to them, that made sense to them in the emotional rather than the cognitive meaning of the term and about which they cared very deeply. Events that occurred in these areas tended

to be regarded as challenges and as worthy of emotional commitment and investment.

By contrast, those who had been classified as having a weak SOC, gave little indication that anything in life seemed to matter particularly to them. What was grudgingly acknowledged as important, took on the tone of imposed wearisome burdens and unwelcome demands that could well be done without. Formally Antonovsky (1987) defined the meaningfulness component of the SOC as the extent to which one feels that life makes sense emotionally, that at least some of the problems and demands of daily life are worth investing energy in and are worthy of commitment. He did not mean that for example, someone high on meaningfulness is happy about the death of a loved one. However, when such unhappy circumstances are imposed, the person will willingly take up the challenge to seek meaning in it.

This echoes strongly with the concept of meaning-making that characterises Viktor Frankl's views on the dynamics of the human personality and his logotherapy (Frankl, 1969). According to Frankl (1959), suffering does not deprive us of our freedom to decide how we will deal with suffering, that is, what attitude we will adopt towards our suffering. He stated that what really matters is the attitude we take towards suffering and the attitude in which we take suffering upon ourselves (Frankl, 1959). If a situation cannot be changed, such as the death of a loved one as provided by Antonovsky in an example above, if suffering such as in this instance, cannot be avoided, what is retained is the freedom to change ourselves. By changing ourselves, if we can no longer change our fate, by rising above and growing beyond ourselves, we exercise the most creative of all human potentials. Suffering has meaning. It offers the opportunity for humans to transcend adversity. This,

according to Frankl (1959), is an aspect of optimal development that he highlights. That mature people, Antonovsky would call them high SOC's, have accepted the tragic factualities of life and have done so in a way that, far from diminishing their joy in life, their belief in the meaning of life is actually deepened. After his experiences in the Nazi concentration camps during World War II, Frankl (1959,p.93) said "The crowning experience of all, for the homecoming man, is the wonderful feeling that, after all he has suffered, there is nothing he need fear any more – except his God."

There seems to be great synergy with Antonovsky's SOC concept of meaningfulness. In terms of these components, a person with a weak SOC, would perceive internal and external stimuli as noise not information, as inexplicable disorder and chaos and as unpredictable in future (Strumpfer, 1990). This person would experience the events of life as unfortunate things happening to him/her, which would victimise him/her unfairly and be perceived as unwelcome demands and wearisome burdens.

2.4.4.4 Definition of the Sense of Coherence

Having discussed the three components of the SOC, Antonovsky (1987, p.19) provides a formal definition thereof: "The sense of coherence is a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable, and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement."

The three components of the SOC are all necessary, albeit of unequal centrality. Antonovsky (1987) states that the motivational component of meaningfulness seems most crucial. Without it, being high on comprehensibility or manageability is likely to be temporary. For the committed and caring person, the way is open to gaining understanding and resources. Comprehensibility seems next in importance, for high manageability is contingent on understanding. This does not mean that manageability is unimportant, for if one does not believe that resources are at one's disposal, meaningfulness will be lessened and coping efforts weakened. Successful coping depends on the SOC as a whole (Antonovsky, 1987).

2.4.4.5 Sense of Coherence and Boundaries

In depth interviews conducted by Antonovsky (1987), he discovered over and over again people whom were classified as having a strong SOC but who did not see their entire objective world as coherent. It became clear that people set boundaries, some wide, some narrow and what happens outside these boundaries, whether comprehensible, manageable and meaningful or not, does not trouble them (Strumpfer, 1990). This boundary notion suggests that one need not necessarily feel that all of life is highly comprehensible, manageable and meaningful in order to have a high SOC. For example, someone may feel that they have little investment in national or international politics, or feel that they have little competence in manual skills, or have a diminished appreciation for classical music, yet still have a strong SOC. The crucial issue says Antonovsky (1987), is whether there are spheres of life that are of subjective importance to that person. If not, then there is little likelihood of having a strong SOC.

However, Antonovsky (1987) stated that there are four spheres that cannot be excluded if the person is to maintain a strong SOC. These four spheres are one's inner feelings, immediate interpersonal relations, one's major activity (invariably this is work) and the existential issues of death, inevitable failures, shortcomings, conflict and isolation. He also expressed the opinion that flexibility about those life areas included within the boundaries may be an effective way of maintaining a coherent view of one's world, by temporarily or permanently contracting from an area whose demands are becoming less comprehensible or manageable, or by including new areas within the boundaries (Strumpfer, 1990).

2.4.4.6 Sense of Coherence and Health

Throughout the salutogenic paradigm, Antonovsky's hypothesis is that the stronger a person's SOC, the more likely will that person be able to maintain their position on the health ease/dis-ease continuum (Strumpfer, 1990), which would be a major determinant of one's state of health. When one looks at the possibility of an integrated psychotherapeutic intervention as being meaningful in the psychological, emotional and even physical (psychoneuroimmunological) aspects of a person infected with HIV/AIDS, this hypothesis is of great importance. However, Antonovsky (1987) stated that at the time of his writing, only inference and specification of hypotheses are possible, because he knew of no data that pointed directly to the link between the SOC, coping and health.

Strumpfer (1990) summarises the basic argument that in terms of the three components of SOC, someone with a strong SOC is more likely than someone with a weak SOC:

- to comprehend the nature and dimensions of an acute or a chronic stressor and to define or re-define it as one to which that person need not succumb.

- to perceive stressors as manageable and therefore to select appropriate resources from those under that person's own control or available from others, rather than to react with helplessness.

- to be motivated to approach stressors as challenges worthy of engagement and investment of energy and as promising meaningful awards, rather than as a paralysing threat that causes one to react with negative behaviour based upon self-fulfilling prophesies.

General resistance resources, whether generalised or specific, are only potentially available. It is up to the individual to activate them in combating and overcoming pathogens and stressors (Strumpfer, 1990). Irrespective of any differences in the availability of resources, people differ in the extent to which they kinetically transform potential into actuality. What provides the difference is the strength of the SOC. People with a stronger SOC are more likely to show a readiness and willingness to exploit any resources that they have at their disposal (Strumpfer, 1990).

This hypothesis rests upon a fundamental distinction between tension and stress. Both concepts refer to emotional and psychological states. Stressors invariably arouse tension. Yet if coping is successful and the tension is resolved, there will not only be an avoidance of damage, but "the very experience of successful coping will lead to emotional

gratification and will have salutary physiological consequences, i.e. the experience will be salutogenic; if coping is unsuccessful, tension, maintained over time is transformed into stress, which, unlike tension, is pathogenic." (Antonovsky, 1987, p.165). This is the indirect, but most important channel linking the SOC to health.

2.4.4.7 Samples of Research (Sense of Coherence)

Antonovsky stated that more research was needed in order to support his SOC health-link hypothesis. Hereunder are some samples of research done in this area.

In an article by Zika and Chamberlain (1992), they put forward that a strong association is found between meaning in life and well-being, which was replicated in two different samples. Meaning in life was found to have a stronger association with positive than with negative well-being dimensions, suggesting the value of taking a salutogenic approach to mental health research.

Bowman's study (1996) empirically validated Antonovsky's suggestion that a SOC is important in managing stress and remaining both physically and psychologically healthy. In both Anglo-American and Native-American cultures, Sense of Coherence Measures were found to correlate negatively with measures of physical and mental distress. This study also supported Antonovsky's prediction that people from various cultures may attain a similar level of SOC, despite great socio-economic differences.

In a study on sense of coherence, negative affectivity and general health in farm workers, Strumpfer (1997) administered interview schedules nine months apart to 79 male first-line supervisors. The first included the 13-item Sense of Coherence scale and the PANAS, from which the Negative Affectivity scale was used. The second included two graphic rating scales for general health. Scores on the SOC and Negative Affectivity correlated -.30, indicating that the relationship is not always strong enough to assume that the former scale measures the inverse of the latter. Scores on the SOC and health ratings correlated .26. This supported the validity of the Sense of Coherence scale as a measure of Antonovsky's salutogenesis construct.

Carstens and Spangenberg (1997), investigated the relationship between major depression and the salutogenic construct of SOC. The Sense of Coherence scale and the Beck Depression Inventory were administered to 50 persons diagnosed with major depressive disorders and to 50 control persons. Significant negative correlations were found between the scores on depression and total scores on the Sense of Coherence scale as well as all three of its subscales, that is comprehensibility, manageability and meaning. A significant positive correlation was found between scores on the Sense of Coherence scale and age. Of the three subscales, the low score on meaningfulness was the best predictor of scores on depression.

In a study of neuroticism and sense of coherence, Gibson and Cook (1996) assessed the relationship of scores on SOC with measures of personality traits. In one group of 95 mixed-sex students, scores on neuroticism bore a highly negative relationship with scores on sense of coherence. Findings supported the literature that personality variables play an important role in general health.

In a study done by Hart, Hittner and Para (1991), which attempted to provide some external validity evidence for the Israeli research linking SOC and anxiety, as well as examining whether anxiety is differentially related to the SOC subscales, the following results were shown. SOC total scores were strongly negatively correlated with levels of trait anxiety. The relative strength of the correlation of anxiety to the various SOC subscales could not be assessed accurately because the SOC subscales were unreliable. Other results showed SOC scores were unrelated to the perceived availability of four different types of social support. These data support the generalisability of Israeli research suggesting that individuals scoring high on SOCA enjoy better mental health than their lower scoring counterparts. In addition, results showing that SOC is independent of socially based stress-resistance resources suggest the SOC scale has discriminant validity.

These examples reflect a sample of the research that tends to support Antonovsky's salutogenic hypothesis which includes the concept of sense of coherence.

One cannot end a discussion on the salutogenic paradigm without including the extended endpoint of that paradigm, which is fortigenesis.

2.4.5 From Salutogenesis to Fortigenesis

Strumpfer (1995) argues that Antonovsky's concept of salutogenesis, which refers to the origins of health, should be broadened to fortigenesis which refers to the origins of psychological strength in general. He states that to emphasise health as the core endpoint of a whole paradigm is to limit the extent of the paradigm. By

defining health as co-extensive with the many other dimensions of well-being, one makes the concept of health meaningless and impossible to study. In other words, the meaning of 'health' becomes overextended and useless for its primary explanatory purpose when it is used as a metaphor for general well-being Strumpfer (1995). A broader explanatory construct is required in order to deal with the interaction between GRR's, the SOC and many areas of human experience, or ease/dis-ease continua.

The term fortigenesis comes from the Latin, *fortis* which means strong, or fortify which means to impart physical strength, vigour or endurance, or to strengthen mentally or morally. It could also mean fort, which is a fortified place, or fortitude which means strength and courage in adversity or pain. This seems to be more descriptive of the paradigm Antonovsky was describing, than the term salutogenesis (Strumpfer, 1995). Introducing this construct is not to deny the need to search for the origins of health, but Antonovsky could not help but point to the closely related origins of the strength needed to be effective at other end-points of human functioning too. "This total endeavour should be acknowledged: 'fortigenesis' is more embracing, more holistic, than 'salutogenesis'" (Strumpfer, 1995, p. 82).

Referring to fortigenesis and fortitude, it reflects a more particular philosophy of life, which is different from a mere pursuit of happiness. That is more what affluent and privileged people from so-called first world countries are able to do. However, it is not necessarily the Weltanschauung of millions of sub-Saharan Africans, not to speak of the multitudes of these who are infected with the HIV/AIDS virus, whose lives are characterised by the human condition of stressfulness and whose lives are a matter of "heterostasis, disorder and pressure towards increasing entropy" (Antonovsky, 1987, p. 2). One only has to be vaguely sensitive in this regard to realise that fortitude is what it most frequently takes in order to carry on with such a life. To deal with the bleak and dismal

landscape of these lives, one needs a particular philosophy and psychology of life, that is concerned with strengths and their origin (Strumpfer, 1995). An understanding of why and how some of these people find the strength to not only withstand, but also to overcome pressures towards increasing entropy, whereas others do not, is also likely to lead to ways of increasing the numbers of those who do (Strumpfer, 1995).

2.5 EXISTING INTERVENTIONS IN THE LITERATURE

In reviewing the existing interventions in the literature regarding people who are infected with HIV/AIDS, it became apparent that the predominant psychotherapeutic approach is symptom-focused and presents psychological problems as inevitable during the course of illness. In fact, in an investigation into the World Health Organisation/Global Program on AIDS (WHO/GPA), Balmer (1992) stated that counselling approaches up to that stage used a disease-centred approach based upon the scientific paradigm, to describe, direct and control the medical response.

At that point in time, the principal aims of WHO/GPA were two-fold. Firstly the prevention of HIV infection through counselling directed at behavioural change, thus limiting exposure to the virus due to the curtailing of high risk practices. Secondly, to offer psychosocial support for those already infected with the virus. In essence, the pre- and post-test counselling, together with the psychosocial support suggested by WHO/GPA, was directive, disease-centred and based mainly upon behavioural psychology. This approach was re-evaluated by WHO/GPA and their conclusions were that given the scale of the pandemic, it had fundamental limitations. Their findings indicated that it would seem to be more realistic to include person-centred and non-

directive approaches (Balmer, 1992). Instead of requiring specified behaviour changes, it was deemed better to make individuals the focus and to provide the maximum level of support.

Further review of the literature also revealed that there was no single way of counselling or "doing" therapy and no monopoly over how HIV/AIDS interventions can best be provided. There are a multitude of approaches to HIV/AIDS counselling and psychotherapy and these many approaches seem to have their strengths in particular areas of focus. In a summary of the main theoretical approaches, Bor and Miller (1991) make mention of the cognitive-behavioural approach, which focuses on thoughts and their affect on experience. They also make mention of the psychodynamic approach which places emphasis on making the unconscious aspects of the experience conscious. Furthermore, Bor and Miller (1991) reflect on systemic therapy, which focuses on the individual as part of a larger system, whether that be the therapist-client system, the family or the wider social system.

In their review of what was the current literature on the psychosocial aspects of HIV/AIDS at that time, Bor and Miller (1991) saw revealed in that review, the fact that many assumptions are made about the impact of HIV/AIDS on people. Psychological problems seem often to be regarded as inevitable and coterminous with an AIDS diagnosis. They further stated that the psychotherapeutic focus was usually on the relief of symptoms, such as anger, depression and withdrawal. They found that assumptions about reactions to a diagnosis on the part of the counsellor or therapist, may impede rather than facilitate the client's management. Resistance and denial may then become the focus of sessions, as counsellors and clients 'compete' to assert their views and beliefs.

Finally, in the review of the literature pertaining to existing interventions for people who are HIV-infected, there was relatively little that focused specifically on the uniqueness of

women and their specific needs. Much focused on HIV-positive gay men and certainly the predominant bulk of literature was from a Westernised, often white perspective. While much was written about the socio-cultural and political implications of HIV/AIDS for women in Africa, as well as the dominant issue of gender and the vulnerability it generates for women in Africa, very little is written about psychotherapeutic interventions for African women. What is mainly written about is pre-test counselling and the acknowledgement that post-test counselling is also required.

2.5.1 The Systemic Approach

Bor and Millar (1991) state that the counselling approach at the Royal Free Hospitals in Great Britain is based on the Milan Systemic Model. This approach guides the counsellor in taking a more neutral view of problems and helps facilitate the counselling conversation through the asking of interventive questions. It is their opinion that the Milan Systemic perspective is not significantly different from other counselling approaches insofar as the conversation between the client and counsellor should facilitate defining problems, solving problems, helping people to grow and to develop, and facilitating the expression of the client's feelings.

In their experience, Bor and Miller (1991) found four recurring themes in HIV/AIDS counselling:

- Secrecy. Because of the associated social stigma, systemic counselling may include discussion on who should or should not be informed about the diagnosis.
- Complexity. HIV infection is complex from a biomedical and social point of view. This means that a large number of people become involved with the

client, which in turn means more professional and non-professional sub-systems. Similarly, there is a greater number of conversations through which problems may be defined or arise.

- Relationships and interaction. HIV/AIDS can create a relationship problem because of contamination fears and the impact of these fears on sexual relationships. This can lead to anxiety about isolation and an inability to enter into or sustain relationships.
- Uncertainty. Much is unknown about HIV/AIDS infection. Clients frequently seek reassurance, certainty and predictability, which is often impossible to provide.

Seventeen tasks for the counsellor/therapist have been developed within the systemic theoretical approach, but may be applicable to other approaches (Bor & Miller, 1991). They are:

- to create a reality with the client which fits the client's current worldview and which will sustain him/her through the periods of change that lie ahead
- to elicit all of the problems, as the client sees them, and then to decide in which relationship areas the client needs to work first
- to determine whether any or which part of the caring sub-system has defined a problem and to have a conversation about the problem
- to discuss the problem in useable language and, together with the client, create a reality of what the problem is
- to retain a degree of neutrality in relation to decisions which clients make throughout the counselling process
- to help the patient-system to continue to grow and develop emotionally and to have some perspective about the future

- to place the responsibility for problem-solving with those who define the problem
- to examine with the client the problem as it is defined and its implications for other relationships
- to help the client not to become stuck around problems and to help a psychologically vulnerable person to cope with additional stresses and thereby possibly prevent the development of major psychological problems. This may involve addressing fears of death and dying
- to talk with the client about issues of unpredictability, which is reality for him/her and may be depicted in questions like: Why should I carry on? How should I carry on? How will the disease progress? What should I do differently? Too much unpredictability in the context of a life-threatening disease may threaten the psychological stability of a person
- to help all parts of the health care system to cope with and make adjustments to emotional and physical losses if requested, by using hypothetical or future-oriented questions while clients are relatively well
- to view HIV/AIDS as the entrée to other problems such as relationship problems and to understand that AIDS may not be the main problem, nor the enduring one
- to examine the difficulties that arise from the client's apparent isolation resulting from fear of social stigma and of transmitting HIV, coupled with a desire to enter into other relationships
- to help the client find meaning, or a new understanding of what it is to have AIDS
- to normalise the views, feelings and experiences of the client
- to help the client to engage with his/her natural support system (family, friends and others) if this is what he/she desires
- to help clients to feel that they have choices and thereby autonomy

While the complexity and unpredictability of the HIV/AIDS disease process does not always allow for definite solutions to be provided, the therapist may attempt to introduce and create an alternative view of the problem which will result in emotional relief. With a systemic approach, the tasks of the therapist will inter alia be to bring out the and define the problem and to become aware of the sub-systems to be addressed (Bor & Miller, 1991).

2.5.2 Existential Therapy in HIV-Related Psychotherapy

Milton (1994) advocates the importance of existential psychotherapy as an approach in the field of HIV-related psychotherapy. He states that Existential Psychotherapy is a school of psychotherapy influenced by the work of existential philosophers and eminent writers on the application of these works to psychotherapy are May and Yalom in the USA, and Van Deurzen-Smith in the UK.

Milton (1994) points to Van Deurzen-Smith as suggesting that the existential approach involves assisting people to come to terms with the dilemmas of living. Issues are addressed in moral terms rather than in terms of sickness and health. The assumption is that people need to find ways of making sense of life before they can make sense of their problems and of themselves.

Many people, whether aware of HIV/AIDS or not, come to therapy for a variety of reasons. An existential perspective might suggest that the dilemmas life throws at us, or that which may be inherent in human existence, creates an impetus that draws people to seek help. These dilemmas may present as depression, suicide ideation, anxiety or a desire to understand a new situation. Any one of these

people may have a concern about HIV/AIDS, or as time passes on it may become an issue. Thus HIV/AIDS may enter a therapy without it being the presenting problem. Alternatively, HIV/AIDS may explicitly be what draws people into therapy. The infection itself may need adjusting to. It can change the way we relate to our body, it can bring social difficulties by way of prejudice and stigma. It may highlight a person's mortality, with an accompanying raise in experienced anxiety or depression (Milton, 1994).

A disadvantage of other approaches such as cognitive-behavioural, systemic and psychodynamic approaches states Milton (1994), is that the client may experience a split, that is as if only one aspect of themselves is related to over a period of time. Certain aspects of themselves are seen as more important than another. Existential therapy has as part of its strength, its central focus on a person's experience, and brought more realistically to work with the balances and imbalances within a person's life. By using the framework of the dimensions of existence, existential psychotherapy attempts to consider the range of experience from the metaphorical aspects of expressed experience, to the social (Milton, 1994). Existential therapy attempts to avoid the trap of getting lost in any one specific area of one's existence and will attempt to keep hold of the wider picture incorporating the dynamics within and between both the internal and external worlds. "Thus, including the emotions that the Cognitive Behaviourists may miss, the Individual that the Systems theorists may not see and the consciousness the psychodynamics may loose" (Milton, 1994, p.3).

HIV infection creates for many people, new and different experiences that were never expected nor previously faced, which may be of a physical, social, intimate or spiritual nature. The existential perspective tries to deal head on with the issues and concerns that face us in our lives and cause us anxiety just by the fact of our humanity (Milton, 1994). It also focuses on the assumptions we come to about the experience of our existence. Therefore it may be particularly suited to

consider the 'givens of existence', as Milton quotes from Yalom's writings, who suggests that these givens are death, freedom, meaninglessness and isolation. Death, because HIV causes people to experience periods of ill health that must be faced as well as imminent death. Freedom, because HIV can force us to explore the freedom we do have and how this is affected once the effects of HIV/AIDS are felt. Meaninglessness, as HIV does not play by the rules that we have grown to expect. Young people instead of old people die and primarily through means of sex, which is the means of expressing caring and starting life. Isolation, because of the threat of social stigma, abuse and those drawing away from those infected (Milton, 1994).

2.5.3 Psychotherapy from a Psychodynamic Perspective

Weiss (1997), who worked with 50 HIV-positive gay men from a psychodynamic perspective, identified central themes such as loss, uncertainty, identity and meaning. He states though, that the concepts discussed are relevant also to groups of other HIV-positive people who differ in terms of sexual orientation, gender, lifestyle factors or nationality.

After finding out that one is HIV-positive can be conceptualised as a series of losses – sense of self as physically healthy, sexual freedom and normal life span – or in fact as feared losses in the areas of normal cognitive functioning, financial security, social support and independence. Weiss (1997) states that as the HIV-positive person confronts their feelings about losses experienced, unresolved feelings related to past losses often emerge. In this way, being HIV-positive provides the person with the impetus to address those unresolved feelings from the past in order to better cope with the current circumstances. Weiss (1997) maintains that HIV-positive men often feel as if they have no control over their illness and that it is something that is happening to them. They feel as if they

have to passively wait and see what havoc it wreaks upon their bodies and lives. He states that it is often effective to intervene at a cognitive level and to encourage the client to consider that he can play a larger role in how his illness progresses. Things which the client can control may be diet, exercise, maintenance of safe sexual behaviour, compliance with medical appointments and treatments, as well as access adequate social support, setting realistic goals and working on feelings and attitudes in therapy.

With progress made in the realm of medical treatment, HIV patients may live longer and the illness may increasingly become something one has to live with. It becomes difficult to plan for the future, not knowing how many years one still has to live. As a result, being HIV-positive, introduces an enormous amount of uncertainty (Weiss, 1997). Often a part of psychodynamic therapy is to help the person to accept and adjust to this uncertainty. Furthermore, if a client is not adequately educated about HIV/AIDS, it would be important to provide such education and thereby relieve many of the fears that can result from lack of information.

Many clients will not necessarily be helped by education alone and ways of adjusting to the uncertainty and losses inherent in the illness. The psychological functioning of the self of the client has also been thrown of balance by the disease. The person usually has personality, developmental, or emotional issues that have not been resolved prior to the HIV-positive diagnosis, which are surfacing at that time, or there are current circumstances which are complicating the adjustment process (Weiss, 1997). A distinction can be made between varying forms of psychodynamic psychotherapy, from the most supportive, to the most insight oriented and exploratory. Supportive therapy usually focuses on symptoms and behaviour change through the support of the client's adaptive defences and environmental resources. Transference is not addressed, nor are attempts made to modify personality or resolve unconscious conflicts. In

dynamically oriented psychotherapy transference is at times used and connections are drawn between current relationships and aspects of the client's early upbringing and past (Weiss, 1997). Once dynamically oriented treatment is underway, the work at times has little explicitly to do with being HIV-positive.

2.5.4 Psycheducational Interventions

In a study of male inmates incarcerated at a prison in the USA, Pomeroy, Kiam and Green (2000) found that a psychoeducational group intervention was effective in increasing knowledge of AIDS and decreasing depression, anxiety and trauma symptoms amongst those already infected. Intensive group experiences of two 90 minute group interventions per week for five weeks was utilised. The conceptual framework also consisted of elements of cognitive-behavioural theory and the task-centred approach, which proved to be effective in the reduction of anxiety and depression as well as trauma symptoms. Group members were also affirmed by their peers and by the group leaders, which had a beneficial effect. The reinforcement of the group was conducive to modifications of feelings and attitudes (Pomeroy, Kiam & Green, 2000).

2.5.5 Positive Psychology, Hope and Resilience

Other important implications for therapeutic interventions mentioned in the relevant literature include positive beliefs and the course of AIDS, hope as a vital resource and strengths based resilience as powerful psychotherapeutic contributions.

Mounting evidence suggests that thoughts, feelings and expectations contribute to health and illness. Psychological beliefs such as optimism, personal control and a

sense of meaning protect mental health. Taylor (2001) states that there is evidence that these psychosocial states predict physical health as well, affecting immune function and the progression of immune-related disease, especially HIV/AIDS. Positive beliefs such as optimism, a sense of personal control and the ability to find meaning in life have an impact on emotional states, which may affect the physiology and neuroendocrine underpinnings of disease states. Such psychological states as depression and anxiety, have a variety of physiological concomitants that have been related to altered immune processes. HIV/AIDS is a valuable context for examining the benefits of counselling in terms of positive beliefs on disease course, in part because it provides and opportunity to examine criticisms of the positive illusions formulation (Taylor, 2001). She states that some psychologists maintain that when terminally ill people realistically accept death as an inevitable outcome, they are being adaptive, allowing themselves to come to terms with their situations and to prepare for their passing. However, Taylor's position argues that positive beliefs transmitted and facilitated in therapy, are psychologically protective, reducing mental distress and potentially retarding disease progression, even at the end of life (Taylor, 2001).

Lazarus (1999) suggests that there has been a great reluctance on the part of psychologists to address the concept of hope. Greater interest seems to lie in the negative aspects of our mental lives, especially helplessness, hopelessness and despair. To hope is to believe that something positive which does apply presently to one's life, could still materialise. It is the belief in a positive outcome (Lazarus (1999). A fundamental condition of hope is that our current life circumstance is unsatisfactory, damaged or threatened, such as a disabling or life-threatening disease like HIV/AIDS. The role of hope in coping is a vital psychobgical resource and without it there is little to sustain the person with HIV/AIDS (or other threat). Hope can galvanise efforts to seek improvement of an unsatisfactory situation. Without hope the person is not likely to act on their own behalf, which is why depression, with its cognitive-emotional background of

despair, is such a dysfunctional state of mind (Lazarus, 1999). Despair undermines and disorganises this process of mobilisation. Hope is said to depend upon self-efficacy as discussed by Bandura (Lazarus, 1999) and self-efficacy, or more colloquially, the self-confidence that a person can control outcomes, gives hope grounds for increasing the odds of a positive result. Hope-oriented psychotherapy in the arena of HIV/AIDS must help the person that what he/she hopes for must change to be consistent with shifting realities.

In the context of hope being a 'galvaniser', Lazarus (1999) points to research where HIV clients were faced with an ongoing threat to their health and well-being. Yet in the face of this extreme and chronic stress, these clients were able to report events and aspects that were very positive in their lives that significantly increased their capacity to cope well. What was interesting in the findings though, was the fact that at least half the positive events or aspects were initiated and effort was made to bring them about. In other words, they did not wait passively for events or aspects to happen, but were galvanised and spurred on by hope that caused them to plan and initiate positive events that generated positive meaning and coping. Lazarus advocates hope-infused psychotherapy.

In reviewing resilience in developmental psychopathology literature, Hawley (2000) describes resilience as individual variation in response to risk and successful adaptation following exposure to stressful life events. Thus resilience surfaces in the face of hardship and carries a property of buoyancy. It assumes that individuals exhibiting resilience are able to bounce back, or rebound from adversity. However, Hawley (2000) also suggests that resilience is generally described in terms of wellness rather than pathology, which Antonovsky (1987) calls a salutogenic orientation. Strengths, rather than deficits are emphasised and are viewed as the resources that allow individuals to overcome adversity, for example such as HIV/AIDS. Nowhere is this strengths approach more evident than in social constructionist approaches to therapy such as solution-focused and

narrative therapies (Hawley (2000). Solution-focused therapy assumes that clients already possess the resources they need to overcome their problems. Therapy focuses on helping them access these resources by developing clear, specific therapeutic goals and then searching for exceptions – ways in which they are already meeting their goals (Hawley, 2000). Virtually any definition of resilience assumes that individuals exhibit a capacity to overcome difficult circumstances through the use of inherent and/or acquired resources and strengths that enable them to buffer the effects of their environments and circumstances to a remarkable degree.

2.6 CONCLUSIONS AND RECOMMENDATIONS

It is very clear from the literature that from a statistical point of view, HIV/AIDS is a rampant killer throughout the world, but particularly in sub-Saharan Africa. The complexities that plague this region such as poverty, denial, poor leadership, illiteracy, women's vulnerability and disenchantment of intimacy (Kopelman & van Niekerk, 2002), make the importance of finding responses that empower its people so vital and critical. The vulnerability of women in the context of gender inequality is a crucial component in slowing down the spread of HIV/AIDS (Women's Health Weekly, 2000).

Empowering women and guaranteeing them their economic and social rights is not an option it is a must. In the AIDS epidemic, it prevents deaths (Gupta, 2001). It ensures that one of the greatest barriers to the health of the populations is eliminated. Empowering women and strengthening them as decision-makers in their own lives, increases the power of households and entire communities. In addressing the contexts in which women live, the position of women in families and communities must be strengthened. HIV/AIDS demonstrates how the prevailing socio-cultural climate in (South) Africa in regard to gender inequality is not simply a matter of fairness and justice. Gender inequality is fatal (Urdang, 2001). Meanings and interpretations

influence all of our communications and so the definition of a good African woman will have to be re-defined (Esu-Williams, 2000). No more can African men decide this and they will have to engaged in changing this definition if progress in the fight against HIV/AIDS is to have any measure of success.

From a therapeutic point of view, it is clear from the literature that many of the therapies originate from outside Africa and that so much of the research has been done in Western societies with greatly differing dynamics to that of Africa. Much of the research has been done in the context of gay men. The opportunity for research and the construction of an integrated psychotherapy for an African context is at hand. It is true that in many of the complexities that pertain to Africa, one is able to relate these to South Africa where HIV/AIDS is proliferating at a frighteningly rapid pace.

It is through the lenses of positive psychology, that the salutogenic perspective of managing stress and staying well becomes very important. The emphasis on origins of health and strength as opposed to a pathogenic, disease perspective on what is a life threatening disease, becomes an enticing context in which to weave a different and more empowering view of psychotherapy.

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