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A COUNSELLING INTERVENTION FOR PSYCHOLOGICAL DISTRESS AMONG PEOPLE LIVING WITH HIV AND AIDS IN THE EASTERN CAPE

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ABSTRACT

The aim of this study was to develop and evaluate the effectiveness of an integrative counselling intervention for people living with HIV and AIDS who are prone to distress in the Eastern Cape. The counselling intervention was developed using a multidisciplinary approach, which included psychological and traditional approaches to counselling. Health care workers and people living with HIV and AIDS were recruited to participate in the development of the intervention. Thirteen health care workers and 18 people living with HIV (PLHIV) participated in the study. The health care workers evaluated the feasibility of the counselling intervention. The findings of the study showed that the counselling intervention content was designed in a manner that appealed to health care workers when providing counselling to PLHIV. The health care workers found the counselling intervention useful but challenging in alleviating distress among clients, as it incorporated counselling dimensions not relevant to the South African context. The findings of the study indicated that there is a need for alternative counselling interventions in South Africa to complement western models of interventions in alleviating distress among PLHIV in South Africa.

Keywords: depression; distress; HIV and AIDS; intervention; stress-related

UNISA university of south africa PRESS

Africanus Journal of Development Studies
https://upjournals.co.za/index.php/Africanus/index
Volume 47 | Number 1 | 2017 | #2063 | 17 pages

https://doi.org/10.25159/0304-615X/2063
ISSN 0304-615X (Print)

INTRODUCTION

People living with HIV (PLHIV) sometimes develop health problems due to the stress associated with HIV stigma and opportunistic infections. Some patients can develop psychosomatic ailments, owing to the psychological stress that comes with being diagnosed with HIV or living with the condition. Health care professionals working with PLHIV in South Africa have been advocating for the development of locally-relevant counselling interventions that could be used by health professionals working in the field of HIV and AIDS.

The study sought to develop a counselling intervention for use by health care workers who provide counselling to PLHIV to alleviate their distress. Thus, the scope of this study covered health care workers and PLHIV. The study also sought to evaluate the perceptions of health care workers with regards to the effectiveness of the counselling interventions they developed to alleviate distress in PLHIV. The study is significant in the sense that the intervention developed will contribute to the development of locally-relevant counselling models for use in South Africa.

The main limitations of the study are that the findings of the study reported only on the experiences of health care workers, even though both health care workers and PLHIV were recruited to participate in the study. The views of both groups could have provided findings that are cohesive.

The HIV and AIDS pandemic is not only a South African problem, but a global one also. It was estimated in 2016 that 36.7 million people were living with HIV globally, and that 1.8 million of the total number was infected in 2016 alone (Avert 2017). In South Africa, 7.1 million people were living with HIV in 2016—18.9 per cent of these were adults, while 270 000 of these had acquired new HIV infections. It is also reported that 110 000 people died of AIDS-related diseases in 2016, in spite of the fact that South Africa has the largest antiretroviral treatment programme globally (Avert 2016).

HIV AND COMORBID CONDITIONS

PLHIV are prone to comorbid conditions such as cardiovascular disease, liver disease, cancer or emotional disorders. They are also prone to psychological problems and neurocognitive disorders such as cerebrovascular disease (Clifford 2017). Depression and suicide ideation could be regarded as comorbid conditions associated with HIV risk behaviour and self-destructive behaviours (Sharp 2017). Moreover, depression is associated with alcohol misuse and smoking (Braithwaite et al. 2016). Significant evidence suggests that PLHIV are particularly vulnerable to psychological distress such as acute stress reactions, anxiety, depression, substance and/or alcohol abuse (Gardner et al. 2016). The physical and emotional distress that they sometimes experience can lead to their health condition deteriorating. Some patients living with HIV may experience feelings of anger, guilt, denial or despair. In some cases people living with HIV may

vent out their negative emotions on their partners and other people—and infect them deliberately.

The comorbid conditions discussed above could be associated with lack of adequate patient care in hospitals, clinics or home-based care facilities. Often, patients end up with undetected psychological problems, which may cause their health to deteriorate to the point of requiring hospitalisation; or could even lead to death (Peltzer 2012). Comorbid conditions such as anxiety, acute stress disorder and post-traumatic stress disorder are commonly diagnosed among PLHIV.

People living with HIV could perceive themselves as victims of the judicial system, owing to the fact that they could be charged for knowingly infecting their partners with HIV (Cox 2016). This implies that criminal law is implemented to curb the spread of HIV—therefore, engaging in sex with someone without disclosing one's HIV status is considered a criminal offence in some countries. In other countries HIV transmission between partners is regarded as a civil matter. Even if the HIV-negative partner does not contract HIV, they can still sue their partner for exposure to HIV. Therefore, it is only when the infected person has fully disclosed their status that they will not be held responsible in the event that the HIV-negative partner contracts HIV (Adam, Globerman, Elliot and Corriveau 2016).

ANXIETY, ACUTE STRESS DISORDERS, POST-TRAUMATIC STRESS DISORDERS AND DEPRESSION IN PLHIV

Wells (2013) argues that how a person responds when fearful and anxious encompasses a package of responses; namely physical, emotional, and cognitive responses. It is argued that fear excites a number of physical responses such as perspiring, rapid breathing, muscle tension, accelerated heartbeat, nausea, trembling, horror and panic. If anxiety is not treated it can weaken the immune system of PLHIV, leading to full-blown AIDS (Cole et al. 2003). The anxiety that PLHIV often experience may be sparked by a concern that clinics and hospitals might run out of antiretroviral drugs, resulting in their health deteriorating.

According to Szabo (2011) individuals experiencing acute stress disorder often experience severe feelings of anxiety and helplessness. They have difficulty taking pleasure in activities that they used to enjoy previously, and can develop feelings of guilt whenever they are supposed to engage in normal, everyday life activities (Szabo 2011). They often have poor concentration levels, sleep disturbances and anger outbursts. Some people living with HIV avoid interpersonal involvement and others loose interest in sex. Dissociative amnesia, irritability and distress associated with exposure to reminders of the stressor are psychological conditions often reported among people living with HIV. Van Dyk (2012) purports that some people experience acute stress disorder after being diagnosed with HIV. Acute stress could disrupt social and occupational functioning.

According to the American Psychiatric Association (DSM IV) (1994, 424) post-traumatic stress disorder (PTSD) is characterised by the "development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury…" A PTSD diagnosis is usually considered if the symptoms of the acute stress disorder persist for more than a month. The symptoms of PTSD could occur at any time following a stressful event, and could persist for longer than a month, while those of the acute stress disorder occur within a month following a stressful event, and could persist from a few days to one month (Van Dyk 2012).

The findings of a number of studies are very consistent in showing that social support helps mitigate the development of PTSD after a traumatic event (Williams and Poijula 2016). PTSD is associated with HIV infection vulnerability and the deterioration of the immune system, which leads to the development of full blown AIDS (Weine, Bahromov, Loue and Owens 2012).

According to Beck and Alford (2009) an individual with depression shows symptoms such as sadness, irritable mood, loss of interest, weight loss or weight gain, loss of energy, insomnia or hypersomnia, hallucinations or delusions. A relationship was found to exist between depression and HIV and AIDS—PLHIV with depression may not follow healthy eating habits and may abuse drugs. They may even engage in unprotected sex (Hill, Maman, Kilonzo and Kajula 2016). Depressive symptoms have also been associated with risk behaviour and non-adherence to medication. Patients with depression are at a higher risk of acquiring comorbid psychiatric conditions and developing alcohol and substance dependency, and are more likely to use illicit drugs; particularly cannabis and cocaine to improve their low mood.

Freeman (2004) reported that in Zambia, 85 per cent of HIV-positive pregnant women had major depression and suicidal thoughts, while in Kampala, Uganda, 54.3 per cent of PLHIV who were attending the The AIDS Support Organisation (TASO) clinic met the criteria for major depression. In Tygerberg Hospital, Cape Town, South Africa, 38.1 per cent of Black and Coloured female HIV-positive outpatient participants met the diagnostic criteria for depression. It was also found that 19 per cent of the women had a history of depression before they were diagnosed with HIV, and 11 per cent of these were deemed to be at risk of committing suicide. Research has also established that in South Africa, even though mental health disorders such as depression, anxiety, and alcohol abuse are commonly associated with HIV, they remain largely underdiagnosed, due to lack of human and financial resources (Joska, Stein and Flisher 2008). In 2005, a study which surveyed PLHIV attending four ARV clinics in Gauteng and Limpopo provinces found that one out of five HIV-positive people suffered from depression or anxiety disorders. It was also found that such patients did not adhere strictly to treatment and some stopped going for medical check-ups and were at a higher risk for morbidity and mortality (Joska et al. 2008).

TOWARDS A SOUTH AFRICAN MODEL FOR PLHIV

Most of the models that were developed overseas are not readily available in South Africa. Also, these models do not address some of the cultural, religious and social contexts in which health professional work. Patients in diverse cultural contexts may present certain behaviours that could be easily misunderstood and misdiagnosed by health professionals due to multicultural factors. This study developed a model that incorporated intrapersonal, interpersonal and contextual factors that influence health behaviour in a South African context.

The study employed a research design as proposed by Rothman and Thomas (1994), which is frequently used by researchers in the field of social development. The model outlined the systematic development of interventions; which included six phases, namely problem analysis and project planning, information gathering and synthesis, intervention design, early development and pilot testing, evaluation and advanced development, as well as dissemination.

The six phases of intervention research are illustrated in figure 1 below as outlined by De Vos (2006).

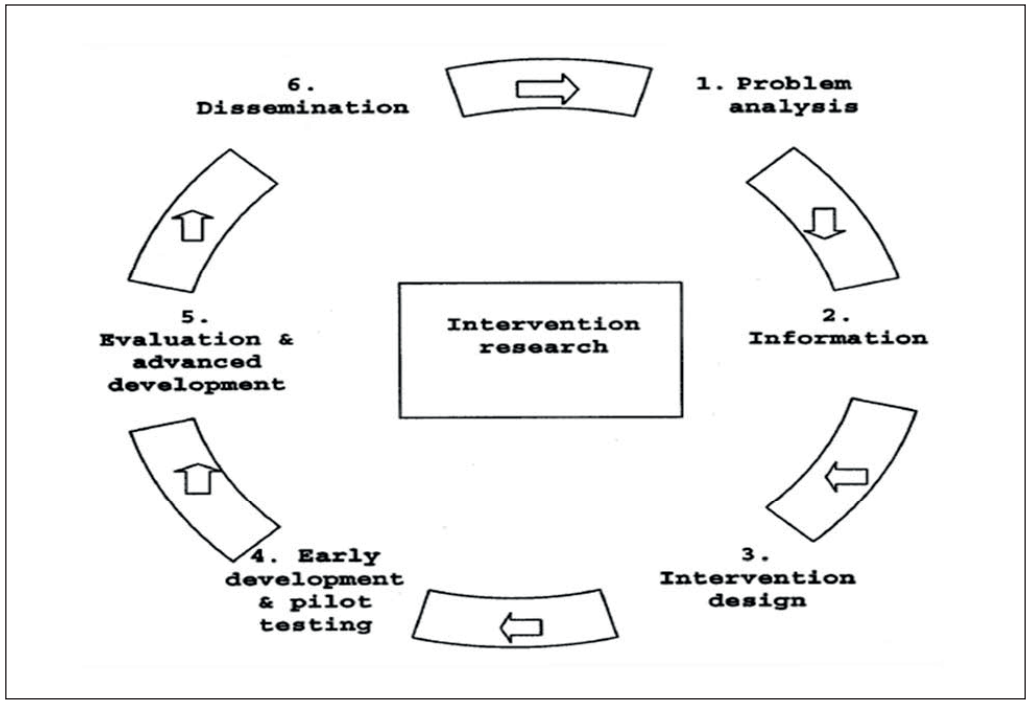

Figure 1: Phases of intervention

Source: De Vos 2006

According to this model, which involves participants, the problem is identified and analysed. Participants are informed about the purpose of the study and the criteria used for selecting study participants. Information is then gathered through a number of existing information sources, identifying functional elements of successful models. Data are gathered and interpreted to develop the intervention. Thus, the intervention is developed, piloted and eventually implemented to its intended population. This study analysed the results and evaluated the implementation of the intervention.

AN INTEGRATIVE MODEL OF DISTRESS FOR COUNSELLING PEOPLE LIVING WITH HIV AND AIDS

An integrative approach in the development of an intervention does not rely on one theory or paradigm. Distress is a general term, which relates to general sadness, anxiety, pain or low affect. Individuals in distress can display symptoms of stress, depression or dissociative disorders. A number of relevant frameworks associated with general distress were considered in designing the model to ensure that the needs of the target population are taken into account. In this case, the experiences and perceptions of people living with HIV and AIDS in South Africa were incorporated in the development of the model. The dimensions that were considered in formulating an intervention model for the relief of distress were **psycho-educational aspects**, **cognitive aspects**, **behavioural aspects**, as well as cultural aspects. These four key factors were given priority in developing an intervention model for the management of distress in people living with HIV and AIDS.

The psycho-educational aspects of managing distress focus on knowledge about the causes of distress as well as the identification of debilitating factors, and how to deal with negative factors to improve one's health. The behavioural aspects of managing distress focus on physical activities that promote good health and reduce distress. Cognitive aspects of managing stress-related ailments are designed to help clients deal positively with negative thoughts. The cultural aspects of the model focus on helping health professionals understand the client's worldview. In developing an intervention model, the health care worker and patient look at psychological distress in the context of beliefs, value systems, tradition, religion, ethnicity and diversity.

THEORETICAL PARADIGMS

The paradigms for developing an intervention model include the psycho-educational approach, body-mind therapy, cognitive-behavioural therapy and multicultural approach.

The psycho-educational approach focuses on patient or client growth through learning. The approach emphasises briefing the patients about their illness, imparting problem solving skills, communication, and self-assertiveness coaching, where relatives of the patient could be present during the sessions (Bäuml et al. 2006). It has been found that patients or clients who lack communication, interpersonal, relationship,

social and coping skills usually recover slowly. Patients who receive coaching to deal with debilitating conditions tend to report less pain, less catastrophising and their health usually show a remarkable improvement (Lovell et al. 2014). The psycho-educational model is relevant to PLHIV in South Africa where patients need information relating to their health and how to cope with HIV, against the backdrop of the erratic supply of antiretroviral drugs and poor health care services in some of the rural areas, farming communities and informal settlements. Accurate information on HIV as an incurable disease should be included in awareness campaigns. The myths surrounding HIV and AIDS should be dispelled, and information on the abuse of antiretroviral drugs by some of the patients in South Africa (Rough et al. 2014) should also be included in the programmes.

Body-mind therapy is informed by the assumption that the body, mind and emotions are dynamically interrelated (Davidsen, Guassora and Reventlow 2016). Body-mind therapies (MBTs) have been proven to reduce stress-related ailments, leading to improved health and wellbeing (Muehsam et al. 2017). To this end, functional genomic and neuroimaging techniques are now employed to assess the efficacy of mind-body therapies in relieving stress-related conditions (Muehsam et al. 2017). Body techniques include physical exercises to train the body to cope with stressful conditions (Gallager 2005).

According to Aposhyan (2007) the human body is capable of healing itself from even the most debilitating experiences; in most cases even without the use of expensive prescribed medication, and often without even seeking medical help. Body-mind therapy combines the strengths of talk therapy with bodywork such as postural alignment or movement education and exercise. Exercises help the body to release a wide range of suppressed emotions (Wienke and Jekauc 2016). This process allows one to be more attuned to their own body, and become conscious of what it really feels like to live in their body, thus enabling an awareness of how one feels when they are anxious, hopeless, needy, desperate, and frightened (Röhricht 2009).

Trauma Release Exercise (TRE) is a technique commonly used in various countries to treat victims of traumatic events such as war, tsunamis, earthquakes, political upheavals, military or violence (Berceli and Napoli 2006). The technique has been designed for use by health professionals such as social workers (Berceli and Napoli 2006). In this study, TRE was used in a way that allowed clients to work through their past traumatic and stressful experiences, through an exercise that induced shaking and tremouring of the body. The client was given an opportunity to reflect on how she/he experienced the process during and after the exercises. The client was encouraged to keep a reflective journal so as to track changes in the tremouring patterns. The reflection on the process assisted the therapist to establish a relationship between the body and mind, and to see where she/he could introduce other approaches such as cognitive behavioural techniques, as well as other therapeutic methods.

Cognitive-behavioural group therapy (CBT) is used to change the client`s distorted ways of thinking and maladaptive behaviour due to underlying depression—it is an approach that aims to solve problems concerning dysfunctional emotions, behaviour and cognitions through a goal-directed systematic procedure. According to Butler, Chapman, Forman and Beck (2006), there is empirical evidence that suggests that CBT is effective for the treatment of a number of conditions including mood, anxiety, personality, eating, stress, substance abuse and psychotic disorders. CBT can be used in individual or group therapy. According to Foa, Rothbaum and Furr (2003), some therapists are more oriented towards behavioural activities and use vivo exposure therapy, while others are more cognitive-oriented and employ techniques such as cognitive restructuring to reduce distress. The two therapies could be combined in imaginal exposure therapy. Moreover, CBT encompasses a variety of approaches and therapeutic systems such as Cognitive Therapy, Rational Emotive Behaviour Therapy, and Multimodal Therapy (Corey 2015).

The scope of CBT is very broad, owing to varying approaches to treatment (Corey 2015). However, commonly used therapeutic techniques include keeping a diary of significant events and associated feelings. The client assesses their thoughts and behaviour, and questions cognitions, assumptions, evaluations and beliefs that might be unhelpful and unrealistic (Corey 2015). Relaxation, mindfulness and distraction techniques are also included. A CBT client takes on valuable homework projects to speed up progress in therapy.

The multicultural approach challenges the notion that problems emanate exclusively within an individual. Corey (2015) argues that multicultural work involves strategies that cultivate understanding and appreciation of diversity in such areas as culture, ethnicity, race, sex, class, religion, disability, and sexual identity. For example, according to the report of the World Health Organization (WHO) (2005) 90 per cent of Africans consult traditional healers. It is possible to include traditional healing or the African worldviews in mainstream health programmes to broaden the scope of health interventions (Mokgotsi 2013). An inclusive perspective could contribute to a positive paradigm shift in the delivery of therapeutic services in South Africa. Culture includes attitudes, values, beliefs and practices shared by a group of people. It could be argued that culture is not rooted in biology, race or nationality but is shown in distinctive behaviours that are handed down from one generation to another in a particular group. Dualism in culture shows dimensions of individualism and collectivism. Individualism refers to the degree to which a culture encourages, fosters, and facilitates a group of people. It influences personal needs, wishes, desires, values and uniqueness of the self as compared to other groups (Van Dyk 2012). Collectivism in Africa is reflected in shared communal values and the obligation to share resources in groups. However, group values and cohesion are threatened by external forces such as poverty, wars, famine, migration, and diseases in Africa.

Africa is a continent that is culturally diversified. Harkness and Keefer (2000) note that although there are cross-cultural and ethnic differences among the people of Africa;

there is nonetheless a general belief that both physical and mental illnesses originate from various external sources such as breach of taboo or customs, disturbances in social relations, hostile ancestral spirits, spirit possession, demonic possession, evil machination, sorcery and affliction by avenging spirits. It should be noted that these belief systems are prevalent in all continents of the world, the difference lies in the manner in which these religious or cultural practices are performed. The traditional practices in Africa attest to the strength of the belief systems (Madu 2015). According to Idemudia (2015) disease causation is associated with both seen and unseen supernatural forces. As a result, unobservable phenomena are embedded in African belief systems, cultural practices, social values, philosophies, and expressions in artefacts of art and poetry. According to Flint (2015), every disease is systematically acknowledged as having a supernatural origin. Collective rituals rather than individual therapies are performed in African countries to cleanse society of diseases (Mokgobi 2014).

Consequently, it is argued that ignoring traditional beliefs in witchcraft and ancestral beliefs could have adverse effects on HIV and AIDS prevention programmes (Van Dyk 2008). The belief systems should be recognised and integrated into HIV and AIDS programmes in a manner that takes into account the feelings of individuals who hold such beliefs. Participants would, within the particular cultural context, learn about the effects of HIV and its prevention (Van Dyk 2012).

METHODOLOGICAL ISSUES

The aim of the study was to assess perceptions of health care workers regarding the usefulness of a counseling intervention developed for people living with HIV. The study adopted a qualitative research design, which took into account the views of participants in the development and evaluation of a counselling intervention aimed at reducing psychological distress among people living with HIV. The study was conducted at two health facilities in Eastern Cape that provide counselling and antiretroviral therapy to people living with HIV.

The study population consisted of 13 health care workers and 18 PLHIV. Informed consent was obtained from participants prior to the commencement of the study. Ethical clearance was obtained from Nelson Mandela Metropolitan University Research Office. Permission was also sought from managers of the health facilities before the study commenced.

Beck`s Depression Inventory (BDI-II) and the Medical Outcomes-HIV questionnaire (MOS-HIV) were used to assess psychopathological traits in PLHIV. A biographical questionnaire was administered to collect personal information from participants; and a focus group schedule was used to interview health care workers.

Participants were invited to participate in the study as they visited the clinics for treatment. Participants were patients who visited primary health care facilities for antiretroviral therapy and HIV and AIDS counselling. They participated in three focus

group discussions to develop and evaluate the counselling intervention for PLHIV. Thematic content analysis was used to analyse the data. Themes that emerged from data analysis informed the findings of the study. Trustworthiness of information obtained was validated through triangulation.

FINDINGS

The findings are reported according to the themes that emerged during the study. The themes are: relevance of theoretical bases of the intervention, relevance of traditional healing practices and usefulness of counselling intervention.

RELEVANCE OF THEORETICAL BASES OF THE INTERVENTION

Participants` views below illustrate the point:

Participant 2: *I explained that we are going to do an activity which involves telling us about your present stressor, its cause and the effect of it in your body. I gave them stress cards you gave us.*

Participant 3: *One of my clients struggled to do this exercise. His situation of not being able to find a job was depressing him. But I explained to him that in as much as this exercise might not help to find a job, he will be able to cope in a manner that will not be detrimental to his health.*

The theoretical approaches of the intervention were utilised by health care workers in helping PLHIV alleviate their distress.

Participant 1: *After demonstrating how to do the exercises, everyone had to do these exercises and this took approximately 45 minutes. I also explained that from today for three weeks one is required to practise at home every day and share the experience when we meet again.*

Participant 2: *My clients shared similar positive reactions to TRE as they continued doing TRE together. CBT was a little challenging for clients to understand as it dealt a lot about feelings, a thing they do not express much.*

Participant 4: *I wasn't sure whether I followed the instructions on CBT well, but with TRE my clients seemed to have enjoyed moving their muscles a bit. They say even though they are encouraged to exercise but they never do it. Now they can see the benefit of it. They thought exercising is for getting slimmer and they definitely did not want to be thin. But now when they can see the benefit emotionally, we then gave them CBT homework.*

Participant 5: *My clients reported that TRE had helped them relax and one said her children were mimicking her thinking she was just doing ordinary exercises. With CBT, a client had to deal with an issue of uncertainty about the future. The client was also worried about the issue of children if anything happens to her.*

Participant 6: *My clients enjoyed this session because it gave them time to release some of the emotional burdens they carry in their struggle of living with HIV. Their issues ranged from fear of their HIV+ status getting known by certain people in the community, fefalling sick to fear of dying while their children are still young.*

The application of the theoretical approaches fitted in well with the activities that were meant to reduce distress in PLHIV.

RELEVANCE OF TRADITIONAL HEALING PRACTICES

The following quotes constitute participants' responses during the discussion on traditional healing:

Participant 1: *I introduced another topic for discussion, `traditional` or alternative ways of dealing with HIV, stress and even mental health illnesses.*

Participant 2: *`When there is a condition that western medicine is not tackling well they seek spiritual guidance from their ancestors through consulting a traditional healer.*

Participant 3: *My clients did not come out clear about this issue. They said some of their family members believe in traditional healers but themselves they have not solicited any help from them,*

Participant 5: *It looks like traditional healing is still held in high esteem by some clients. They believe that traditional healing has its place in their lives and seeking ancestral guidance and protection is very important. They still perform such traditional rituals as required by their own family tradition. Even though some consulted traditional healers before they got to know about their HIV+ status, they do follow up on western medicine to heal them physically. Some would seek help from traditional healers when western medicine has failed to yield relief. They will go to' isangoma' so as to communicate with the ancestors and seek direction on the condition presented at that moment.*

Incorporating traditional healing methods in counselling sessions was received positively, although participants indicated the merits and demerits. Some of the PLHIV revealed that they used both conventional medicine and traditional medicine.

Using Cognitive-Behavioural Therapy (CBT) seemed to be challenging for both health care workers and PLHIV. Some health care workers encountered difficulties trying to explain the concept and others requested the researcher to provide clarity before the health care workers met with participants. The health care workers reported

that some of the participants had difficulties going deeper into their feelings about their HIV status and relationship with their partners and family members.

Participant 1: *With CBT clients noted how they talk themselves to failure. They also noted that they sometimes use anger to express these feelings of failure. The couple was able to connect after talking about how they treat each other. Getting insight on why they react the way they were reacting to each other assisted them to connect in a positive and encouraging way. Lay counsellors will be able to continue with this intervention in the support group as a way of alleviating stress among its members.*

Participant 2: *Even though they were excited about exercises, they were struggling to look inward during CBT sessions. One client said `This is challenging because I have never heard anybody asking me about how I feel. I am the one always focusing and making sure everyone is happy.*

The use of CBT by counsellors proved to be challenging in the sense that underlying feelings of distress sometimes surfaced as anger or unhappiness.

USEFULNESS OF THE COUNSELLING INTERVENTION

The comments below shed more light on the usefulness of the counselling intervention:

Participant 1: *My clients reported feeling alert and very light. One client said, `It feels like a heavy load has been lifted off my back.*

Participant 2: *They said that learning about how stress affects their bodies and eventually causing many illnesses have been an eye-opener to them*.

Participant 9: *Another client told us her story about how she has been looking at herself in a negative way. `Ever since I was diagnosed as HIV positive, I lost self-confidence and I have not been able to see myself as a person who can be attractive to men because I feel ashamed that I have this disease. It's like everybody looks at me like I'm dirty and it stresses me a lot. I sometimes feel safe when I'm alone`. She said that being able to talk freely about how she feels has given her a new look in life and she will continue with positive self-talk.*

Participant 10: *I had two cases that made me think deeply about my capability to help people. Even though I am a nurse I have not explored my participants' feelings and thoughts before. I have been a more physical person focusing on the illness. Now I was challenged to get to know my patient deeply. I must say it is difficult but not impossible.*

DISCUSSION

The views of health care workers regarding the usefulness of the counselling interventions suggested that the intervention was acceptable to PLHIV. The theoretical bases of the counselling intervention, traditional counselling approaches and counselling activities were evaluated as useful in reducing stress in PLHIV. The content and activities performed by participants during stress-reduction activities were considered suitable for the target population. The theoretical bases of the intervention made the intervention more appealing to people living with HIV and AIDS. The theoretical foundation upon which the intervention was built, which included the psycho-educational approach, mind-body therapy, cognitive-behavioural therapy and multicultural approach made it easier for health care workers to elaborate on the level of distress associated with HIV and AIDS, and to engage participants in activities that made PLHIV realise what they needed to do in order for them to cope with HIV and alleviate their distress.

The psycho-educational content was evaluated positively by participants when they were asked to identify their stressors and the effect of stress on psychological functioning. As such, participants learnt about their condition and ways to prevent distress.

The knowledge obtained equipped participants to live positively with HIV. The learning activities also led them to open up and to talk about the myths that they needed to deal with in order to improve their wellbeing (Rough et al. 2014).

The content of the intervention, which incorporated body-mind therapy was appealing to participants. Health care workers found that the TRE technique encouraged participants to engage in activities that would reduce their level of distress. Stress was released through relaxation activities (Berceli and Napoli 2006). The group exercises enabled participants to have a sense of a collective, with the sole purpose of recovering from HIV-related debilitating conditions. Exercising helps the body to be in good shape—a fact that health care workers emphasised to PLHIV—that they could improve their health and body image through TRE exercises. In South Africa, few adults living with HIV and AIDS engage in physical exercises to enhance their wellbeing. Participants in this study reported that exercises relieved distress and helped them sleep well. The exercises reduced minor health complaints such as headaches. This confirms the effectiveness of the mind-body therapy as reported by previous researchers (Muehsam et al. 2017).

Cognitive-behavioural therapy techniques were evaluated positively by health care workers, who indicated that the therapeutic techniques influenced PLHIV to change their way of thinking. The techniques used by health care workers enabled participants to think positively about their health condition and future prospects. Some participants indicated that they were distressed by past traumatic events. The content of the counselling intervention enabled health care workers to elicit the repressed unwanted memories in participants (Gardner et al. 2016; Hill et al. 2016). Previous research has

shown the connection between homework and patient recovery among patients with depression undergoing cognitive-behavioural therapy.

The multicultural approach was found suitable by health care workers in reducing distress in PLHIV. Participants held perceptions on HIV and AIDS that were explained in terms of culture and religion. The results confirmed the findings of previous studies that the majority of patients in Africa visit traditional healers more than they visit hospitals and clinics (WHO 2005). Participants in this study confirmed that they had visited traditional healers before. The findings of this study are in line with the findings of the study by Madu (2015) and Idemudia (2015), which indicate that in Africa illness cannot be separated from religion and culture. The incorporation of multicultural elements in the counselling intervention made communication on reducing HIV-related distress easier between health care workers and PLHIV.

The perceptions of health care workers were that the intervention suited their cultural environment. Health care workers were able to establish good rapport with PLHIV and harmoniously worked together on therapeutic tasks. Health care workers helped PLHIV identify their stressors by allowing them to talk about their health concerns, and assisted them with techniques to lessen the effects of debilitating conditions. This technique is used in psycho-educational approach and CBT to help clients accept their illness and also help them find ways of coping with it (Corey 2015). The theoretical approaches helped health care workers to understand concepts related to psychological distress.

CONCLUDING REMARKS

The integrative counselling intervention comes at a time when diversity of approaches is needed and should be promoted in South Africa. Cultural sensitivity is required in counselling to accommodate national values and belief systems. South Africa is a diverse country that would benefit from counselling interventions that are not narrow in scope. The counselling intervention is expected to help PLHIV cope with the distress they experience in their daily lives. As such, the findings suggest the need to implement culturally-relevant programmes that would provide coaching to PLHIV that would help them alleviate their distress. The recommendations of this study are that the intervention should be based on theoretical frameworks that are relevant to the target population and should be designed to address the needs of society.

ACKNOWLEDGEMENT

This article is based on Nomvula Twaise`s unpublished PhD draft thesis. Twaise is registered at Nelson Mandela Metropolitan University.

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