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Experiences of HIV/AIDS Counselors in Zimbabwe and Their Perceptions on the State of HIV/AIDS Counseling in Zimbabwe

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This study investigated Zimbabwean counselors' experiences of providing HIV/AIDS counseling and their perceptions about the state of HIV/AIDS counseling in Zimbabwe. The participants were a diverse group of counselors, 30 through 59 years of age, who provided counseling services to HIV/AIDS clients. Participants thought HIV/AIDS counselors in Zimbabwe received minimal support and supervision and were undertrained. They identified that the first sessions with clients were the most difficult. They also found it problematic to work with couples who were serodiscordant (one partner who is HIV positive and the other HIV negative) and couples wanting children. The later stages of the counseling process were also found to be challenging. Though the participants acknowledged they had negative psychological experiences when counseling HIV/AIDS clients, they also expressed feelings of satisfaction and fulfillment in their work.

KEY WORDS: HIV/AIDS counseling; counseling in Zimbabwe; counseling ethics; counselor struggles; counselor burnout.

Acquired Immune Deficiency Syndrome (AIDS) has become the world's foremost health threat, with Southern Africa being the hardest hit region in the world. In Zimbabwe, a Southern African country, an estimated 3,290 people die of AIDS a week (United States AID, 2004). Acquired Immune Deficiency Syndrome is the later stage of the Human Immunodeficiency Virus (HIV) infection. According to United Nations AIDS (UNAIDS) (2004), in 2003, 1.8 million persons in Zimbabwe were thought to be living with HIV and the estimated HIV infection

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rate for adults (those in the 15–49 year age group) was 24.6%. It is believed that 200,000 people in Zimbabwe died of AIDS in 2001(UNAIDS, 2002). Life expectancy in Zimbabwe has dropped to 35.4 years (United Nations Development Program, 2003).

In regard to HIV/AIDS and youth in Zimbabwe, the World Health Organization (2003) conducted a study to assess the HIV infection rate of youth between 15–29 years of age. Of the 3,833 male participants tested for HIV, 10.3% were HIV positive, and of the 4,280 female participants, 21.8% were HIV positive. According to the United Nations Children's Fund (UNICEF) (2002), today's 15 year olds in Zimbabwe are more likely to die of AIDS than not. UNAIDS (2004) reported that 980,000 AIDS orphans (children who have lost one or more parents to AIDS) were thought to be alive in Zimbabwe in 2003. UNICEF (2000) estimated that 277,117 orphans in Zimbabwe had died since the start of the epidemic.

Despite these grim statistics, it is considered that through a multisectoral approach the HIV epidemic can be managed. One practical way of helping to contain the virus is through the provision of HIV/AIDS counseling. With nearly 25% of adult Zimbabweans believed to be HIV positive there would be few counselors who did not have HIV/AIDS clients, or clients who were the "worried well" (those who fear they may have HIV, but do not). Since counselors can play a vital role in both prevention of HIV/AIDS and the care of people with HIV/AIDS (Moyo, et al., 2002), it would be important to augment or enhance counselor training, support, and supervision in a way that developed the counselor's ability to help their HIV/AIDS clients. This would be particularly true in the Zimbabwean counseling context, since at best the majority of counselors in Zimbabwe are trained to the para-professional level (Richards, 2003). Therefore, this study investigated a small group of Zimbabwean counselors' experiences providing HIV/AIDS counseling and their perceptions about the state of HIV/AIDS counseling in Zimbabwe, in order to identify potential professional needs of HIV/AIDS counselors.

DESIGN OF THE STUDY

Participants

Availability and snowball sampling (Monette, Sullivan, & DeJong, 2002; McMillian & Schumacher, 1989) were used to identify participants for the study. The participants consisted of eight Zimbabwean counselors – 30 to 59 years old, four male and four female. Half the participants were in jobs where they exclusively counseled HIV/AIDS clients. The rest had jobs that were not specific to counseling HIV/AIDS clients, but they regularly had people with HIV/AIDS as clients. All of the participants worked in public settings; additionally one had a private counseling practice.

It was important to the researchers to try to be inclusive of as many diverse voices as possible because during Rhodesia (colonial Zimbabwe) the colonizers' voices were given precedence. The participants of the study represented the four main "racial" groups in Zimbabwe (Black, White, Colored, Asian-Indian). Additionally, counselors equally represented rural, high-density, town, and city settings. Two participants came from each of the following areas in Zimbabwe: Chiwesha communal area in Mashonaland, Inyanga, Mutare, and Harare.

Counselors in Zimbabwe have various levels of training ranging from several hours to many years. Six of the participants had between 10 and 1,080 hours of HIV/AIDS counselor training. Two of the participants reported that they trained full time as HIV/AIDS counselors for eight and twelve weeks respectively. The participants had the following counseling qualifications: three had certificates in family counseling, one had a certificate in child counseling and development, one had a diploma in addictive behaviors, one had a certificate in family therapy, one had a two-year course in theology that included classes in counseling, and one participant had a certificate in counseling from an international non-governmental organization (NGO).

Sources of Data

The main sources of information for the study were a demographic questionnaire and telephone interviews. Additionally, data were obtained through follow-up questions emanating from both the telephone interviews and member checks involving obtaining feedback from the participants to verify the researcher's interpretation of the data. The follow-up questions and member checks were carried out through the electronic mail.

The Questionnaire

General demographic information, such as age, ethnicity, gender, education, and contact information was collected. As well, such information on where the participants were born and where they received their counselor training, was collected. This was to insure that the participants were all Zimbabweans, and had received their counselor training in Zimbabwe.

The Telephone Interview

The literature was used to guide the researchers in the development of the interview questions. These questions were sent for review to individuals who were brought up in the Zimbabwe indigenous culture, who were experts in educational research in Zimbabwe, and who also had counseling qualifications.

The interviews were conducted over a span of two months at the convenience of the participants. They lasted between 45 to 90 minutes and were audio tape-recorded. Though the questions were set in advance of the interviews, during the course of the interview new questions inevitably arose. Notes were taken after the conclusion of each interview. After the initial interview, participants were contacted in order to clarify certain responses they made. Additionally, participants were contacted at least twice for member checks (Gall, Borg, & Gall, 1996).

Data Analysis Procedures

The data were obtained from the interviews, interview notes, and post interview questions. Each tape was listened to at least twice so that the researchers could gather a greater understanding of the participants' responses (Kruger, 1979). The tapes were then transcribed and coded. The coding process for this study was complex. Open coding (Strauss & Corbin, 1990) of the data occurred. In this case, the data were examined line by line, in sentence combinations, paragraphs, and by comparing each interview to one another. It was through the coding process that categories, themes, and ideas emerged. Furthermore, axial coding (Strauss & Corbin, 1990) was carried out. Data that seemed related were looked at in the context of one another. For example, the categories of training, supervision, and areas of difficulties counselors experience during the HIV/AIDS counseling process, were examined together and separately. These independent and collective categories were reviewed on several occasions in an attempt to comprehend any meanings that may become apparent to the researchers. Categories with limited data were eliminated and the data contained in them were included into other pre-established coding categories when possible.

RESULTS

The results are divided into six sections. These sections are 1) Counselor Support, 2) Counselor Supervision, 3) Areas of Difficulties in the HIV/AIDS Counseling Process, 4) Psychological Experiences Counselors have when Counseling HIV/AIDS Clients, 5) Counselor Meaning, and 6) Techniques and Concepts Counselors Utilize.

Counselor Support

The participants thought that support services for counselors providing HIV/AIDS counseling was an important issue that did not seem in general to be well addressed in the Zimbabwe context. The counselors were asked, "What support services are available to HIV/AIDS counselors in Zimbabwe?" Counselors

Three, Four and Five thought that there was little support for counselors in general and spoke about counselors becoming "burned out." For example:

> There are limited training and support mechanisms and they need to be developed. Counselors here keep burning out and they are leaving because they do not have support. (4)

Counselor Six thought not only were counselors not getting support, but that they also were not sharing what resources they did have. Counselor Eight, the director of an organization that assists HIV/AIDS clients, expressed that in her organization and at the voluntary counseling and testing centers (VCT) that counselors could receive support and training. She mentioned that she was "frequently out of office at conferences and other events" and she said:

> There are courses offered like at [organization's name withheld] for renewing and enhancing one's skills. At the VCT the coordinator arranges refresher courses for those doing counseling for testing for HIV. Counselors also facilitate at workshops for training of the trainers and this can also be seen as a support system for them. (8)

However, Counselors Two and Five, who were also employed in the same organization as Counselor Eight, had a different perspective. Counselor Two thought that some support existed in his organization, but not for the counselors. Counselor Five said:

> I feel like for me there is no support network or system institutionally or professionally. I do not think that HIV/AIDS counselors as a whole in Zimbabwe are getting the support they need. Generally organizations lack support so the counselor can decline in their skills and burnout. (5)

Training, sharing of resources, group/dyad meetings with other counselors, and information were perceived as being forms of support by the counselors. In regard to the availability of information, Counselor One was asked "So how easy is it for you to get updated information, or the most recent information on your areas of interest?"

> It's OK, obviously on the Internet that is one source that is pretty up-to-date, and true libraries and things, and journals particularly, and we are linked with other AIDS organizations both in this country and outside. So we are linked with organizations that are really good in keeping us informed. So the information is there, it's just a matter of being interested enough to maintain. I noticed that a lot of my colleagues are not the least interested, so they're way behind in their knowledge, but it's there if you wanted. There is no shortage of it at all. (1)

The responses seem to indicate that counselors in large metropolitan areas, or in positions of authority, may have more access to support, resources, and information than those counselors in mid to small sized towns, and that counselors in rural areas do not have access to support, resources and information. It appears that some counselors may not be aware of the needs of counselors outside their own professional circles. This is not surprising because the counseling profession in Zimbabwe is not organized.

Of interest is that Counselors Three, Four, and Five's statements above referred to the occurrence of counselor burnout. Counselor Two mentioned the stress involved in being an HIV/AIDS counselor. Counselor burnout and stress in regard to HIV/AIDS is not limited to counselors in Zimbabwe. Reports of HIV/AIDS counselor burnout in Australia, Eritrea, Ghana, India, Kenya, Malawi, South Africa, Thailand, and Zambia, indicate that burnout may be a common occurrence, particularly for those who lack counselor support and/or supervision (AIDS Analysis Africa, 1995; Boswell et al., 2002; Maria, Paranthaman, & Nanmozhi, 2002; and Taegtmeyer et al., 2002).

Taegtmeyer et al. (2002) and Guinan, McCallum, Painer, and Dykes (1991) indicated that the use of counselor support and supervision could reduce burnout and increase the quality of the counseling services provided. However, supervision in Zimbabwe may be less available than support services.

Counselor Supervision

The participants in general thought that HIV/AIDS counselors in Zimbabwe received inadequate supervision. For example:

> I cannot say I have much supervision because at [name of organization withheld] in [name of place withheld] part of supervision is done by the Ministry of Health, so supervision is limited. No one comes and says "how many clients did you have this month and so on" . . . so there is really not much supervision. (2)

> Well, some organizations send their staff for further training and doing a bachelor degree but after training there is no support. They say you are already trained, you do not need support now, just do your job. So, there is some training, but no supervision. (5)

> Supervision is an area that needs to be developed. We have been putting all our focus on developing them [counselor trainees] as counselors but we have completely ignored mechanisms of support . . . I did develop a counselor supervisors' course and delivered it to some of my counselors that have been counseling for some time—they also counsel clients but they also supervise junior counselors . . . (4)

> Supervision is the most important factor. I don't know how I would survive if my organization did not provide supervision. To me supervision would be the sharing of information and techniques and suspected failure. (3)

The participants seem to define supervision differently. Counselor Two defined supervision as a process that is rather didactic and involves a supervisor asking questions and the supervisee providing the answers. Counselors Four and Five viewed supervision as a form of support. Counselor Three's view of supervision appeared to be a peer supervision model as opposed to supervision with an evaluation component. In general little is actually known about counselor supervision in Zimbabwe, or in Africa at large.

The lack of supervision of HIV/AIDS counselors is not surprising. Boswell, Sangria and Kamenga (2002) observed voluntary counseling and testing centers (VCT) in the countries of Australia, Eritrea, Kenya, South Africa, Thailand, Zambia and Zimbabwe, and reported that there was a lack of supervision and

support services for VCT counselors. Hargreaves et al. (2002) evaluated VCT services in Lilongwe, Malawi and found that VCT counselors lacked regular supervision and support services. Taegtmeyer et al. (2002) reported that in Kenya VCT counselors experienced burnout and recommended that counselors attend regular support sessions with knowledgeable counselors. This lack of supervision may make it difficult for many Zimbabwe counselors with limited training and counseling skills to effectively carry out HIV/AIDS counseling.

All of the counselors in this study, except one, stated that HIV/AIDS counselor training in Zimbabwe was extremely limited with most counselors being trained from only one to three weeks. They also indicted that those under-trained counselors lacked the skills needed for the job. For example:

> .... so it [counseling] has become a buzz word, and it is absolutely meaningless because people have been put on these 'so called' counseling courses, sometimes for as little as a week or two, and go out into the community and call themselves counselors, and I think there is a lot of damage being done. (1)

Counselor Seven, who was based in the communal areas, thought that though Zimbabwean counselors were well trained, she herself was not well trained

> I think I have not had enough courses, and having no one to discuss with, ish ["ish" is an expression with no direct translation, but in this case may be interpreted as "for goodness sakes"] we could meet other counselors at workshops to discuss these things. (7)

Of importance is that Counselor One mentioned that this limited training and supervision for HIV/AIDS counselors could result in counselors psychologically damaging their clients. Richards (2001) also identified this problem of lack of training in Zimbabwe in relation to psychological damage to clients. In order to reduce the potential for such damage and enhance in general the quality of HIV/AIDS counseling and counselor supervision, it would be important to identify what parts of the HIV/AIDS counseling process do counselors find difficult.

Areas of Difficulties in the HIV/AIDS Counseling Process

The counselors were asked, "What part of the HIV/AIDS counseling process is the most difficult for you?" The counselors were very forthcoming in regard to the difficult aspects of HIV/AIDS counseling. They seemed to be eager to talk about the difficulties they experienced when counseling HIV/AIDS clients. Four counselors (Counselors Two, Three, Five and Seven), mentioned that the initial aspects of the counseling process were the most difficult. They spoke about the difficulty of getting through the denial stage with the client, how hard it is to broach the topic of HIV, and building the counseling relationship with the client. For example:

> I suppose what's the most trying is when they first come and you're trying to get to grips with what they know, what they suspect, what you know, and what you suspect. So it is that

> initial period when you kind of play a bit of a game which I find probably the most hard to get the client to be concrete. (3)

Three counselors (Counselors, One, Three and Eight), mentioned that the later stages of the counseling were the most difficult or equally as difficult as the initial sessions. One counselor said the anger of the client in the later stages of the disease was difficult to manage. The counselors said it was also difficult for them in the later stages of the counseling process because of how the client physically appeared and because of the "yo-yoing" of the client's health. Two counselors (Counselors One and Three), both described the difficulty experienced by the client, the client's family, and the counselor when faced with the client's 'back-to-back' illnesses that seemed to linger on. Counselor One said:

> I think where you have those 'back-to-back' illnesses and the very disturbing physical manifestations of it. I find to the eye it is very distressing. It looks horrible, very horrible, and I know it is really awful for the people. I think that is the most distressing and the fact that it carries on, it lingers, so it seems there is no end and I think it is one of the situations where euthanasia seems quite appealing and it's that winding down of lots of terrible things happening to the client that I can't bear. That in itself is really hard, It is tiring and gives false hope, it is exhausting for the family. (1)

Counselors One, Five and Six mentioned that counseling couples was the most difficult, and two of those counselors also mentioned the difficulty in counseling couples around the issue of having children:

> Well, particularly where you have the very difficult situation, where one partner being positive and one being negative. I think that's perhaps the most demanding scenario and, and certainly trying to prevent the one partner from becoming infected, and by making considered choices about children and the future. (1)

One counselor mentioned that counselors in Zimbabwe were generally good in basic counseling skills, but that they have difficulty in handling the various problems that HIV clients have:

> I think the most difficult part is the problem management. We need to take into account that the problem is that the counselors have not had adequate time training. Nearly 60% of them are nurses so they are fairly good in information and in rapport, they are fairly good at probing and exploring, they are pretty good at showing empathy. But when the problem has been identified, they do not know what to do. (4)

Some of these findings are similar to the findings of the HIV Counselling Research and Evaluation Group (1999). This research group reported that issues of HIV status disclosure, discordant status of partners, and related partner issues in couples counseling were stress points for counselors. Grinstead and Van der Straten (2000) also reported similar findings "Some counselors reported feeling overwhelmed by couples in counseling sessions. Many mentioned the stresses of counseling serodiscordant couples . . ." (p. 641).

In this study, only one counselor (Counselor Six) had a difficult time talking to clients about issues of human sexuality. In the study conducted by the HIV

Counselling Research and Evaluation Group (1999) and in Baggaley, Sulwe, Kelly, Macmillan, and Ndovi (1996) the counselors reported being uncomfortable in having to address issues of sexuality with their clients. Zimbabweans in general are hesitant to speak about issues of human sexuality. This anomaly may be a result of an attitude or belief that counselors carry, as Counselor Five said:

> Even though it is taboo [to talk about sexual related issues] unless we break those barriers we will never solve this issue of HIV. (5)

It may be a matter of training. Counselor Four, who was involved in counselor training in Zimbabwe stated:

> . . . we encourage and train them [counselors] to feel OK to talk about sex. (4)

All of the counselors thought that HIV/AIDS counseling in Zimbabwe was a difficult task. Counselor Three said:

> Sometimes we [HIV/AIDS counselors] feel we are in a helpless situation, we just feel helpless, overwhelmed by every little thing. How can you possibly help the HIV/AIDS client, it is rather difficult. Though it is rather helpless I kind of feel though if I can make even the slightest effort, that even if I am just somebody they [HIV/AIDS clients] can talk to, that that is better than nothing. (3)

Though not directly related to the difficulty of the counseling process, but perhaps indirectly impacting on the counselors' work, four of the participants informed that counseling as a profession was not recognized in Zimbabwe and that counselors were poorly paid. For example, Counselor Five relayed:

> . . . [counselors] can burnout., not only in terms of financial support, but in terms of [limited] staff development. Counseling is not seen as a profession, so the remuneration level is pathetic. (5)

According to Moyo et al. (2002) at a VCT site in Chitungungwiza, Zimbabwe, 34 counselors, in return for being trained for two weeks by this VCT organization, were obliged through a legal contract to work for this organization for a period of two years. For their services these counselors received a salary the equivalent of US$20.00 per month for 16 hours of work.

Psychological Experiences Counselors have when Counseling HIV/AIDS Clients

The participants reflected on their psychological experiences when counseling HIV/AIDS clients. They revealed that they felt uplifted and hopeful, and said they believed they were useful and helpful. Counselor Five spoke about feeling hopeful and also providing clients with a sense of hope:

> Personally, may be because of the work I do, or the training I have undergone, I feel hopeful when counseling HIV/AIDS clients. Sometimes my first thought is to work with the person and give them hope. (5)

The counselors had feelings of admiration and respect for the clients' determination to live with the struggles of being HIV/AIDS positive. For example, when asked, "When a client reveals that they are HIV positive what kind of thoughts and feelings do you have?" Counselor Four said:

> I admire them, I think they are very brave and I at the same time see if I can get a picture of the family and see who else might be affected by this. (4)

Though the participants had positive psychological experiences when counseling HIV/AIDS clients, during the interview they dwelt more on their negative experiences. The counselors reported experiencing conflict, anger, fear, sorrow, frustration, horror, irritation, ambivalence, shock, apprehension, remorse, and also having feelings of inadequacy. The counselors described themselves as sometimes feeling helpless, hopeless, and overwhelmed when counseling HIV/AIDS clients. The counselors reported that HIV/AIDS counseling was psychologically trying and tiring. Additionally, they stated it was anxiety and stress provoking.

In regard to their ability to help, the counselors revealed that they experienced self-doubt. Though the participants in this study were trained and experienced in working with HIV/AIDS clients, all the participants except one (Counselor Seven) experienced feelings of inadequacy in relation to counseling HIV/AIDS clients. Counselor Eight said:

> The problem is when you are dealing with human lives every case is unique and different from the first one. A counselor is bound to feel inadequate because each case is different so they may not know what to do. (8)

Anger seemed to be an important issue for the participants and six of the counselors were willing to openly discuss their feelings of anger. They experienced anger for a variety of reasons, such as the government's lack of response to the health crisis, anger with client behavior particularly when the person knowingly infects innocent people, and lack of counselor support. Counselor Six relayed:

> . . . when I can't get a client to understand and they act in a way that endangers others I get angry. Say you have a couple, and the HIV positive husband refuses to tell his wife that he has HIV. Other times the couple will blame each other for the HIV, no one wants to be responsible and you have to listen to them argue. (6)

Capone (1992) reported that half of the counselors in his study also experienced anger with client behavior.

Five of the counselors indicated that they felt helpless at times during the counseling process. The counselors responded that feelings of helplessness came from working with clients with limited financial resources because the clients could not take care of themselves; from being in similar circumstances as the client (that is the counselor may be HIV positive or have a significant other who is HIV positive); from the overwhelming nature of the problem; from hopelessness, knowing that the client will die no matter what counseling

was provided; and from lack of training, supervision, and support services. For example:

> I think it is the magnitude of the problem that makes counselors feel helpless . . . (2)
>
> Counselors can also start feeling helpless because of their limited skills. (3) It can make you helpless and hopeless because you see that people have an infection that cannot be cured. (5)

The HIV Counselling Research and Evaluation Group (1999) related that counselors experience stress and hopelessness in regard to the overwhelming nature of AIDS.

The counselors were asked, "What part of the HIV/AIDS counseling process is the most frustrating for you?" All but one of the counselors (Counselor Four) conveyed their frustrations in terms of the client. The parts of HIV/AIDS counseling process that the counselors felt most frustrated with were the "yo-yo" effect of the clients' health, clients that would not take responsibility for their problems, clients' responses to the results of an HIV test, youth clients who did not take the situation seriously, lack of client progress, and lack of training. Counselor Six reported:

> You can see some very young people being HIV positive and when you are talking to them [you realize] they are going about having sex with anyone even though they are HIV positive. They can bring AIDS to their spouses or partners. (6)

All of the counselors were aware that they experienced particular feelings while counseling HIV/AIDS clients. These feelings were both positive and negative. The feelings in some cases were directed at the client, at other times at the counselors themselves, or at the environment (political, social, cultural, and economic contexts).

Counselor Meaning

The findings seem to indicate that HIV/AIDS counseling in Zimbabwe is a complex and difficult task. Because of the potential difficulties of providing HIV/AIDS counseling, the lack of professional recognition, and limited financial incentive, the researchers wondered if the participants were able to find satisfaction or meaning in their role as HIV/AIDS counselors. The data were then examined to see if the participants indicated that they found meaning in their work. Comments made by the counselors suggested that despite the difficulties, they found personal meaning or satisfaction in counseling HIV/AIDS clients. One of the questions asked of the counselors that seemed to have the potential for discerning meaning was, "How do you think counseling can help with the AIDS problem?" Counselors One and Two thought that counseling could help the individual learn to live with the virus psychologically. For example:

> . . . with very good counseling you can make a major difference both in terms of adaptation to the virus and ways of living and owning your own responsibility with sexuality, as we

> well as maintaining your health. . . . Counseling can transform a client into someone who can tackle life head on again, it is very rewarding indeed. It feels great to see people regain their wholeness and to be able to live as fully as possible until they die. (1)

Counselor Three viewed counseling help in terms of the development of support systems for clients:

> . . . you see what you can do in the practical side which is getting orphaned kids into school, finding an organization which will bring in meals on wheels or food parcels or find accommodation for them where the landlord is going to evict . . . We try and get organizations to back them up and then we will go and start trying to deal with the initial issues, which are dying, leaving their children behind, anger issues, and a lot of the other stuff in the emotional arena. (3)

Counselors Four and Six saw counseling as a form of HIV prevention. Counselor Four said:

> Counseling is one of the important interventions that will help with the containment of the virus. . . . Counseling will play the part of augmenting prevention efforts. . . . Counseling will have one very important effect, it personalizes these messages and it has an impact at the personal level. (4)

Counselor Eight disagreed that counseling could be used as a form of prevention but did think it could help people after they were infected to cope with their illness and that counseling can:

> . . . give a sign of hope and extended life . . . and prepare a person for death." (8)

Counselor Five also thought counseling could help the client feel hopeful. Counselor Seven thought that counseling can provide education/information and can be comforting:

> It will help by giving comfort and education to those who have HIV/AIDS. (7)

When asked, "Did counseling an HIV/AIDS client ever make you examine your personal meaning of life?" Counselor One said:

> Yes, absolutely and I think this is why counselors in this job find it so appealing as the regular reflections on life and death must make a big impact on their approach to life, relationships, choices, etc. It is certainly why I feel so inspired in my job, and why I feel it is not depressing. Rather it makes me appreciate every day as I know how easily it can be taken away. (1)

It seems the participants had found meaning in their role of providing HIV/AIDS counseling. They believed they could make a major difference in the lives of those with HIV/AIDS (Counselor One), reunite families (Counselor Two), help clients acquire and maintain the basic necessities of life such as shelter and food (Counselor Three), contain and prevent the virus from spreading (Counselor Four), provide information and hope to individuals and communities (Counselor Five), teach clients to use their medicines and learn how to live a good and healthy life (Counselor Six), give needed comfort and education (Counselor Seven), and

teach clients how to live their life as an HIV positive person, extend life, and prepare clients for death (Counselor Eight).

Others have reported this sense of meaning in HIV/AIDS care workers as well. Ross and Seeger (1988), and Bennett, Miller and Ross (1995) identified that HIV/AIDS workers gain a great deal of satisfaction from their work. Guinan, McCallum, Painer, and Dykes (1991) and Kleiber, Enzmann, and Gusy (1995) relayed that HIV/AIDS workers had a greater sense of personal and professional accomplishment than other workers in health care, such as those who work with the elderly or cancer patients. Hoffman (1997) identified that HIV/AIDS counselors experienced both stressors and rewards in the course of their work.

Techniques and Concepts Counselors Utilize

Though not a focus of the study, during the course of the interviews, the counselors revealed the techniques and concepts they applied to working with their clients. For example, the counselors stated they used encouragement, the core conditions, genograms, psycho-education, and role playing. They indicated they used cognitive behavioral, psychodynamic, humanistic, and systemic approaches. However, of particular interest was that two techniques and one core condition emerged that are not typically found in the westernized versions of counseling. These techniques or concepts may have derived from the clients' inabilities to speak directly about HIV/AIDS and issues with sexual content. Counselor Three referred to "going around the corner" to help the client speak about his/her problem. In putting this technique into practice the counselor hints at what the problem is and then waits for the client to hint back. The counselor then hints again. This process of hinting continues until the problem is identified:

> Yes, that's right, it's all very loose and that's why you have to 'go around the corner' often, you drop lots of hints and they drop lots of hints and eventually you get to it. (3)

Counselor Five mentioned "mind reading" as a technique. In this case the counselor states what they believe is on the client's mind:

> Clients can have a hard time talking about HIV because of the taboos around it so you may have to 'mind read' the client. (5)

This idea of "mind reading" as a technique may make a lot of sense in the Zimbabwe context. If a client visits a traditional healer, the client may expect the healer to identify both the problem and solution through mind reading or other supernatural methods (Mbiti, 1991). However, the counselor may misread the client. When using this technique, the counselor should already have a grasp of what they think may be the client's problem and also be prepared to admit any inaccuracies they made in the process of "mind reading."

Counselor Two mentioned "no witch hunting." This is more of an attitude the counselor develops and perhaps could be classified as a core condition in

counseling in the Zimbabwe context. Though this attitude may be somewhat related to being non-judgmental it has more depth to it, as in the process of witch hunting an entire community may be frightened and turned upside down as witches are "sniffed out." Previously good relationships among community members may be destroyed in the witch hunting process. Hence, in enacting this condition, the counselor would avoid blaming or "sniffing out" clients, their family members/significant others in relation to who brought HIV and other problems into the family. This is typically a situation that counselors find themselves in, that is, family member/significant others blame each other for bringing HIV into the marriage/relationship. The counselor should not blame or try to determine who is at fault and should focus on getting family members to avoid fighting over this issue during the counseling sessions. This condition would not only be limited to HIV/AIDS counseling scenarios, but really to any other counseling scenario. More in-depth, this condition could also imply that the counselor uses their personal/professional "power" in a positive way with the client and not, for example, exploit the client's vulnerability.

CONCLUSIONS

The findings indicated that participants think that training, support and supervision of HIV/AIDS counselors in Zimbabwe is limited. Though the participants seemed well trained, they reported that most HIV/AIDS counselors in Zimbabwe were not. They relayed that most counselors did not have adequate support and supervision. Most of the counselors in the study reported they also received little in the way of support, supervision, or ongoing training. It appears that those who already possessed the most training, education, and resources, were more able to access continued training, education, and additional resources, than counselors who were less trained, had less education, and had less resources. These counselors with their resources and opportunities may not be aware of the limited resources and opportunities that other counselors in Zimbabwe have. The development of a professional counseling association in Zimbabwe may help with the dissemination of information on counseling issues, bring to the forefront the issues that counselors face and the experiences they have, and bring together counselors for advocacy purposes.

The findings suggest that the early stage of the HIV/AIDS counseling process is the most difficult part for the counselors. Other areas of difficulty are the later stages of the counseling process, having a couple with discordant HIV results, and counseling HIV clients who wish to have children. Initial sessions may be easier for the counselors to handle if they used techniques such as "going around the corner" and "mind reading," and if counselors bring with them to the counseling session a "no witch hunting" attitude so the client feels a sense of safety. The curriculum at counselor training sites could be further developed to train counselors to specifically cope with these

and others aspects of the HIV/AIDS counseling process that counselors find difficult.

In regard to their psychological experiences while counseling HIV/AIDS clients, the participants revealed that they experienced feeling uplifted, hopeful, useful, and helpful. Though the participants had positive psychological experiences they also reported they experienced conflict, anger, fear, sorrow, frustration, horror, irritation, ambivalence, shock, apprehension, remorse, inadequacy, helpless, hopeless, and overwhelmed when counseling HIV/AIDS clients. The counselors also reported that HIV/AIDS counseling was psychologically trying and tiring and that it was anxiety and stress provoking. These negative types of experiences need to be handled through support and supervision services. During counselor training students can be made aware of the potential to have such psychological experiences and how they can manage them.

Zimbabwean HIV/AIDS counselors appear to be under extreme stress from their jobs as HIV/AIDS counselors. Despite this stress, the counselors in this study have found personal meaning in providing HIV/AIDS counseling to their clients. Helping HIV/AIDS counselors find this sense of meaning and fulfillment may enable them deal with the stress of their jobs and avoid burnout.

Potential Ethical Issues Related to HIV/AIDS Counseling in Zimbabwe

Since counseling and psychology codes of ethics indicate that mental health specialists should not provide services they are not qualified to carry out, what are the ethical implications of this in relation to what the findings revealed about the Zimbabwean HIV/AIDS counseling scenario? The findings do raise thorny questions. For example, is it ethical to provide counselor training that is inadequate, or to train counselors where there is no system of counselor support or supervision? When there is anecdotal information available that some of the under-trained counselors may have psychologically damaged clients, is this not an ethical issue on several levels, particularly when little or no provisions are made to find solutions to such issues? Are some of these counselor training organizations making money at the expense of the psychological wellness of their "graduate" clients? On the other hand in the case of Zimbabwe, a developing country that has few professional counselors and other mental health providers, is some counselor provision better than none? Would it be unethical to offer little or no services when so many individuals are in need such services? Is it ethical to have counselors who are denied professional recognition and expect them to take on one of the most demanding roles in Zimbabwean society? The Health Professions Council does not offer counselors recognition, even for professionals with doctorates in counseling.

Suggestions for Future Studies

The findings of the study provide direction for future research. Studies need to be conducted that look at how HIV/AIDS counselors might best receive support

and supervision services, and the quality of these services. Of importance may be what preferences do HIV/AIDS counselors in Zimbabwe have in regard to supervision and support as Westernized perspectives of supervision and support may not be relevant to the Zimbabwe context. Given that little information is available on counselor supervision in Zimbabwe, such studies could provide needed insight and information.

The participants of the study were functioning as professional counselors. It would be important to examine the knowledge, attitudes, feelings, and perspectives of para-professional counselors as well, particularly since they make up the majority of counselors in Zimbabwe. This would provide important information in regard to the needs of para-professional counselors in Zimbabwe and provide a more rounded perspective of the situation of HIV/AIDS counseling in Zimbabwe.

Since all the counselors in the study experienced feeling inadequate when counseling HIV/AIDS clients, it may be an area worth exploring. Why do trained and experienced counselors feel inadequate when counseling clients with HIV/AIDS related issues? Answers to such questions could significantly advance HIV/AIDS counselor training and practice in Zimbabwe and elsewhere.

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