

Group Counseling Training in Sub-Saharan Africa for HIV/AIDS Human Service Personnel

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This paper will describe a group counseling training program being conducted in sub-Saharan Africa. Human service personnel and others dealing with the HIV/AIDS crisis are being trained in group counseling methods in a collaboration between Indiana University, the African Association of Guidance and Counselling, and the University of Botswana. This paper will outline the developmental history of the training program and will give an update on the ongoing project. It will demonstrate how current methods of counseling in sub-Saharan Africa are not meeting the demands from communities. Short-term individual counseling with no follow-up cannot begin to address the needs of: a) stigma and discrimination, b) the needs of AIDS patients in hospital and outpatient settings, and c) the vulnerable population of orphans and their living circumstances. Future assessment and research plans are also outlined.

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The AIDS Epidemic and the Need for Group Counseling in Sub-Saharan Africa

Globally, approximately 40 million people were living with HIV/AIDS in 2004. Of that group, 25.4 million lived in sub-Saharan Africa (UNAIDS/WHO, 2004). Thus, over 60% of the people in the entire world living with HIV/AIDS are in one region: sub-Saharan Africa. This region has an extremely high proportion of individuals dying from AIDS; 74% of all individuals who died last year due to AIDS were in sub-Saharan Africa. This translates into 2.3 million adults and children dying last year (UNAIDS/WHO, 2004).

In Africa, HIV/AIDS impacts economic, social, and political spheres of society. One damaging aspect of HIV/AIDS is that it affects the most productive section of the population, those people between the ages of 15 and 45 years of age (Tripodi & Patel, 2002). HIV/AIDS causes a severe decline in health workers, teachers, and creates millions of orphans; causing an economic and social crisis which can lead to threatening political instability (Henderson, 2001). Because of this decline, a sub-Saharan country with a 20% HIV rate is estimated to have a GDP growth rate that would be 2.6% less each year. In twenty years, the GDP would be 67% less, due to the impact of HIV/AIDS (Yung, 2001). The impact on economic, social, and health programs will be grim because of this decrease in GDP.

A country in sub-Saharan Africa that is particularly devastated is Botswana. It has one of the highest HIV prevalence rates in the world, currently at 38%. But perhaps more disturbing is that this devastating rate has shown *no signs of leveling off* (UNAIDS/WHO, 2003). This has caused the life expectancy in Botswana to fall below 40 years (UNAIDS/WHO, 2004).

One way to address the impact of HIV/AIDS is through counseling. Unfortunately, current methods of individual counseling for people living with HIV/AIDS in sub-Saharan Africa are not meeting the demands from communities. Typical counseling consists of a pretest

counseling/informational session, testing for HIV, and a posttest session; often each session is only 15-20 minutes long (Pronyk et al., 2002). Counseling in this short duration, with no follow-up cannot begin to address needs such as stigma and discrimination (UNAIDS/WHO, 2003), demands for counseling without testing (Kipp, Kabagambe, & Konde-Lule, 2002), the vulnerable population of orphans and their living circumstances (Yung, 2001), and the lack of normal mourning practices which fracture communities and families (Kilonzo & Hogan, 1999). Current forms of individual counseling are not dealing with ways in which HIV/AIDS tears the social fabric of communities.

The role of the community is a foundation of indigenous African culture (Haegert, 2000). In this way, African countries are collectivist (Triandis, 1989). Haegert pointed out that “individuals in African cultures see their community as an extension of themselves” (2000, p. 496). Thus, personal identity is subsumed under group identity. Any intervention which does not incorporate the community is not utilizing African’s traditional way of living. The group serves as an agent of change; when individuals are not incorporated into a decision making process they “may question their citizenship rights and exit the community” (Patterson, 1999, p. 2).

Several authors have focused on the need for HIV/AIDS interventions in Africa to expand from an individual focus to a community focus, and the benefits and facilitation of change from such an expansion (Campbell & Rader, 1993; Campell & Rader 1995; Seeley & Wagner, 1991). This proposed shift from an individual focus to a group and community focus is in line with Africa’s basic approach to health care: community-based or collective (Haegert, 2000). Group counseling can provide such a shift. Balmer (1994) found that group counseling in sub-Saharan Africa offered a group identity for individuals, which is especially therapeutic for

people who are socially stigmatized (such as those with HIV/AIDS). He found that group counseling offered a better form of support for those with HIV, even better than the support provided by friends and family. Another advantage of group counseling is that it is an intervention that can be provided at relatively low costs compared to individual counseling. This is salient given the anticipated decrease in GDP that countries with high HIV/AIDS rates will face in the coming years (Yung, 2001). Unfortunately, group counseling is extremely underused.

In one of the few instances of recent group psychotherapy use in Africa, Bolton and colleagues (2003) reported success for decreasing depression-like illnesses, depression symptoms, and associated dysfunction (Bolton et al., 2003). In an article in the *New York Times* featuring the interpersonal group therapy treatment Lacey (2004) cited the lead author, Dr. Bolton, on the study who said, "So much attention is being paid to AIDS but so little is being done about the mental health aspects of the disease" (p. 1). The demonstration of the efficacy of group counseling in the United States is wide spread (Barlow, Fuhriman, & Burlingam, 2004; McRoberts, Burlingam, & Hoag, 1998; Smith, Glass, & Miller, 1980; Tillitski, 1990) and Bolton's (2003) study provides initial support for the benefit group counseling can have in Africa.

In designing interventions for sub-Saharan Africa it is crucial not to impose Western methodologies. It can be beneficial to utilize the methods already found in the communities. Loewy, Williams, and Keleta (2002) demonstrate a culturally sensitive intervention with East African refugee women by combining the Kaffa ceremony (a traditional East African coffee ceremony) with group counseling. This served as a bridge "between traditional views of helping and Western counseling" (Loewy, Williams, & Keleta, 2002, p. 175). This integration of existing methods of helping in indigenous African ways, combined with group counseling, offers

a powerful approach to work with diverse populations.

Developmental History of the Group Counseling Training

The project to train human service personnel in group counseling interventions began when the President of the African Association of Guidance and Counselling (AAGC), Dan-Bush Bhusumane, contacted Rex Stockton, Chancellor's Professor in the Department of Counseling and Educational Psychology at Indiana University. Mr. Bhusumane requested assistance with training in group work procedures for those who were doing frontline work in Africa, starting in Botswana. This country was selected for a pilot training because there was already a group of individuals who expressed interest in receiving training in group work. Additionally, it was hoped that group work could help address the difficulties caused by Botswana having one of the highest HIV/AIDS prevalence rates in the world.

The primary goal of the pilot program was to educate counselors and other human service personnel from Botswana in the methods of group counseling. To accomplish this a culturally sensitive method for group counseling training was developed. The developers of the program include: Dr. Stockton, Mr. Bhusumane, Dr. Keith Morran, and doctoral student Leann Terry.

Initial Training: Process and Outcome

At the request of the President of the African Association of Guidance and Counselling (AAGC) a team from the Botswana Guidance and Counseling Association (BGCA) selected individuals for the training. Potential participants were contacted by letter inviting them to apply for participation. The number of participants was kept deliberately low in order to maximize the training. However, because of demand the number was increased to 15 participants. The final group of participants included individuals from public education, the university, government ministries, health care, and the military. The diversity of the group was intentional. Participants

came from organizations where they were mental health providers or leaders from those organizations. Thus, the training provided resources and experiences for the service providers who would be running groups in the future as well as those who could administratively encourage and facilitate the use of groups in their settings.

The initial goal of the training was to introduce basic principles and practices of group counseling. In August 2004 Dr. Stockton and Mr. Bhusumane conducted a week-long training at the University of Botswana in Gaborone, Botswana with additional support from Dr. Nancy Stockton. The first day and a half was devoted to didactic instruction. Each day of training started at 8:30 am and ended at 4:30 pm. Participants viewed instructional videos, participated in lecture/discussion, and were given a great variety of printed materials and access to web-based resources in the group therapy area. Topics covered included: group characteristics at different stages of a group (Corey & Corey, 2001), feedback exchange (Morran, Stockton, Cline, & Teed, 1998), processing (Glass & Benschhoff, 1999; Stockton, Morran, & Nitza, 2000), and leader interventions (Morran, Stockton, & Whittingham, 2004). Not only were participants taught how to facilitate feedback between members based on empirically supported guidelines (Morran, Stockton, Cline, & Teed, 1998) but they also experienced it through feedback exchange with each other in the working group formed near the end of the training. This integrative process utilized several modes for training group counselors: didactic instruction, participation in groups, and observation (Toth & Stockton, 1996).

In the middle phase of the workshop some direct teaching continued but more time was devoted to allowing group members to utilize group facilitation skills in small practice groups. Participants used role plays and practiced specific interventions in these groups. Members appreciated beginning to experience the development of trust and cohesion in their groups in a

comparable manner to their development in the real world groups they planned on forming. All this was done with every attempt on the facilitators' part to be cognizant and respectful of cultural norms and differences.

The final stages of the workshop involved the participants more directly experiencing group principles at work, as they formed a working group and discussed the challenges of their daily work in a world devastated by HIV/AIDS. One of the leader's role in a group is to facilitate member to member interaction, as interactions between group members has been shown to have the most impact on change (Dies, 1983). In the working group this principle was modeled by the trainer through facilitation of member to member interaction. As Dies (1983, 1994) indicated in his reviews two key aspects of group facilitation are to have an appropriate amount of structure in a session and to facilitate a safe climate. These principles were iterated throughout the training with an experiential component demonstrating the application of it in the last phase of the training. As is often the case in group counseling work, through the process of forming a group the members' trust, confidence, and levels of cohesion were enhanced.

The workshop presenters understood that the amount of material presented was impossible to assimilate in a short period of time. Thus, provisions for continued interactive web-based communication after the conclusion of the workshop were introduced to the participants.

The general themes of the discussions in deciding how to best use the information, insights, and experience from the training included ways to use group counseling: in working with teachers and the orphans in their classrooms, using it for culturally sensitive and efficacious preventive and treatment measures, and as a way to address the denial surrounding HIV/AIDS.

The first theme that was brought up was that group counseling could be a useful method

to support teachers working with AIDS orphans. By 2010 it is estimated that 21.6% of all children in Botswana will be orphans, (USAID, 2002). Teachers are working with children who very recently lost parents. This places teachers in the obviously difficult position of trying to meet these children's emotional needs as well as teach them.

A second theme to the discussions of how group counseling could be used revolved around working with HIV/AIDS patients who have a variety of views about causes and treatments for their illness. These include beliefs that it is "God's will" and man should not intervene, beliefs in indigenous African healing principles and trust in modern medications. In effect, this topic was concerned with both prevention and treatment compliance.

The third area discussed was the role of denial with regards to serious illness, which was described as a basic cross cultural human tendency. Just as cancer or syphilis were not openly discussed in western cultures for many decades, similarly HIV/AIDS is very frequently not directly recognized in African cultures today.

In conducting the training, there were two questions that were extremely important to be answered. The first was whether or not the material that was put together from western sources would be accepted by an African population. The second was whether it would be presented in a way that would be culturally appropriate. These questions and others were addressed in an evaluation form given at the end of the training.

On the evaluation all participants strongly agreed that they would recommend the workshop to other professionals in Botswana and other African countries. In response to the statement, "This workshop increased my group counseling skills" the average score on a 1 (strongly disagree) to 5 (strongly agree) Likert scale was 4.93. One participant wrote regarding this statement, "It not only increased the skills, but most importantly set up a spark for me to get

going” [participant’s emphasis]. When asked to rank whether the workshop was culturally sensitive and respectful of African traditions, the participants also rated this highly, with an average score of 4.79 on the Likert scale. In response to the cultural sensitivity of the workshop one of the participants wrote, “Exceptionally well. This aspect was well done” and another, “As is [sic] counselling, nothing was imposed on anyone”.

Several weeks after the training, Mr. Bhusumane wrote in an email correspondence, “I had a chat with some of the people who heard about the training. They indicated that those who participated told them how good the training was and were already expressing their desire for participating in the future training that might be available”.

In view of the positive responses and feedback Mr. Bhusumane, as President of AAGC, has recommended that the program be made available to other countries in Africa. Multiple countries including Kenya, Ghana, and Rwanda have already expressed interest and commitment to the training that might be made available through the African Association of Guidance and Counselling. Contacts with country coordinators have already been established. As Mr. Bhusumane reports, the need for group counseling cannot be overemphasized. Group counseling seems to fit very well with the African cultural environment and current practices of providing services for mental health and social support.

Future Trainings

The next round of training, with anticipated trainings in Kenya will start in August 2005. The intent of the next round is to establish a larger base of trained individuals. This will form the nucleus of participants who will, in turn, become the next group of trainers. The goal is to move the program toward self-sufficiency. Additionally, establishing a network of trained participants will assist those who are often living in communities where this network has been fractured,

through HIV/AIDS, civil war, or other traumas (Levers, n.d.; Vollmer & Valadez, 1999), in addition to providing support for subsequent training. The participants being trained are experts in their local culture and thus will be able demonstrate a high level of cultural specificity in the following trainings for their target populations. In moving towards a self-sufficient program the intent is to develop a program where external and non-local leadership becomes obsolete.

To accomplish the goal of expanding the trainings, a larger pool of participants will be developed as time progresses. Additionally, Dr. Stockton has been granted a sabbatical for the 2005-2006 spring semester. This will allow him to be in Africa to conduct more trainings, including anticipated ones in Botswana, Kenya, and Rwanda. This will create a larger base of individuals trained in group counseling skills, thus creating the foundation for a self-sufficient program.

Collaborating with other organizations will also aid the goal of expanding the trainings. A key collaborator in this phase of the project is Dr. Michael Reece, the William L. Yarber Professor in Sexual Health in the Department of Applied Health Science at Indiana University. Additionally, Dr. Reece is a Research Fellow of the Rural Center for AIDS/STD Prevention with a research interest in HIV-related mental health care. Dr. Reece and Dr. Stockton have been invited to visit the Indiana University School of Medicine-Moi University collaborative program in Eldoret, Kenya. The IU-Moi program joined with the Kenya Ministry of Health and Moi Teaching and Referral Hospital to create a model of urban and rural HIV treatment and prevention (Einterz, Mengech, Khwa-Otsyula, Greene, Tierney, & Mamlin, 2003). The program in Kenya demonstrates an excellent response to HIV/AIDS from the medical model perspective, but they recognize that it has a minimal focus on the effects of HIV/AIDS on mental health.

Several key strategies used for this project were identified at a conference hosted by the Regional AIDS Training Network (RATN) and The International HIV/AIDS Alliance which focused on expanding HIV/AIDS trainings (RATN & The Alliance, 2001). The first of these strategies, *participant selection*, is a key element of the culturally sensitive approach of the current project. A team from the Botswana Guidance and Counselling Association determined the first round of participants to be trained, thus the selection was not externally imposed. Participants will continue to be chosen by regional counseling associations or other local groups in the respective countries. Secondly, a main focus of the current training program is to *increase the coverage*, as evidenced by plans to train participants in Kenya, Rwanda, and additional groups in Botswana. The *quality of the trainings* will continue to be evaluated with the assistance of Dr. Morran and Dr. Floyd Robison, colleagues of Dr. Stockton. Finally, two crucial strategies of *training the trainers* and *building strategic partnerships* are evidenced above. These strategies are being used to accomplish the goal to expand culturally sensitive group counseling trainings.

As demonstrated, there is a very great need for counseling that is appropriate for people facing one of the gravest social and individual problems the world has experienced. Previous efforts to address these problems have rarely taken advantage of the richness of group counseling. This project is an attempt to provide training that will have a substantial impact on the communities and lives of those in sub-Saharan Africa. Future plans include using the findings from the project to inform the development of culturally relevant programs appropriate for other countries and cultures facing the HIV/AIDS epidemic.

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