The Message Behind The Voicelessness of People Infected and Affected by HIV/AIDS: Narrative Approach Perspective

Leepo Modise[1]

Author detail

Department of Philosophy and Systematic Theology,
University of South Africa, Pretoria, South Africa

Corresponding author

Leepo Modise
Department of Philosophy and Systematic Theology,
University of South Africa, Pretoria, South Africa
P.O. Box 392, Unisa 0003 Pretoria RSA.
Email : modislj@unisa.ac.za.
Phone +27124294646

Abstract

This article consist of five main parts: First reception of messages about HIV/AIDS in Africa during 1980s. During this period African leaders receive this message differently and had responded differently, this will be discussed in this article. Secondly, to describe the resaerh method employed in this article. Thirdly, how these different approaches in different countries impact on the openness of the people about their HIV/AIDS status. Foruthly, the messages that need to be externatised through narractive counselling. Fively, how narrative approach can be used to externalise the message behind the voicelessness of these people.

Key words: Voicelessness; HIV/AIDS; Narrative approach; Externalising and Counselling

INTRODUCTION

HIV/AIDS has been a problem for Africa and the global world in the sense that, it does not have any cure. HIV/AIDS is a topic that has been greatly discussed and researched due to its' impact on human life. Ever since the HIV/AIDS was identified, human beings have been attempting to find ways of educating and assist others to cope. In this article, the author discuss the four critical issues for this articles namely: Firstly, the reception of the messages about HIV/AIDS in Africa in the middle 1980s and responses from different African leaders. Secondly, the approaches to this pandemic have impacted in different ways (Openness or closureness approach to the problem). Thirdly, narractive approach will be proposed as the means to externatized the problem of HIV/AIDS in Africa. Fourthly, there will be recommendation for the training of faith Leaders and laity from different community to utilize narractive approach to assist people infected and affected to disclose or externalize the message behind their voicelessness.

Background of HIV/AIDS in Africa

In this background the author will focus on four African country regarding reception and reaction of heads of state or state in the 1980s. These countries are South Africa as the country where the investigative centre is situated as well as Kenya, Senegal and Uganda. It is recorded that the first time when African leaders and African people hear about HIV/AIDS in the middle 1980s there was a different reactions to HIV/AIDS. These different reactions have impacted on policy-making, medience and health care (Patterson, 2006:2). The philosophy of the country also played the major role for example in South Africa, the policy of apartheid influence the thinking of policy maker based on race, sex and class.

In South Africa during that period, the reaction was racist, classist and sexist in nature. White people of South Africa were not associated with the HIV/AIDS, but it was associated with blacks, homosexuals and working class. Patterson (2006:2) indicates: When the first AIDS cases appeared in Africa in the mid-1980s, state reactions varied widely, the apartheid state assured white South Africans the disease was confined to "deviant homosexuals" or poor black migrants from neighboring countries. In effort to blame the outsiders, and in a move that provided false comfort to the population, between 1988 and 1992 the government

repatriated about 13, 000 Malawain miners, because roughly two hundred of them had tested positive for HIV in 1987.

In this sense many people who were tested HIV positive choose to hide the message due to the reaction of the government by then. This is an indication that governments and politicians did not face the reality of researching the cure or the ways to help people to contract to this disease. The philosophy of Apartheid limited the thinking of the white South African and the state to race, sex and class as the carrier of HIV/AIDS.

Fortin (1987:906) argues that in Kenya it was reported in their news that "Killer disease in Kenyan," medical officers were in the state of denial that HIV/AIDS is reality and public in Kenya. Instead of reporting the HIV/AIDS related death, they claim four AIDS death was related skin cancer. The reaction to HIV/AIDS at this country was more of a secret or internatized measure known by the medical officers but not the people infected and affected by the virus.

The Senegalese and the Ugandeans choose to follow a different approach to HIV/AIDS, they choose to speak out about the disease in private and public. The two countries leadership were frank and open about HIV/AIDS, while accepting that there is a challenge that need to be addressed. Patterson (2006:2) indicates: President Abdou Diouf of Senegal openly acknowledged AIDS in his country and began national AIDS prevention and control programs in 1987. President Yoweri Museveni of Uganda started public discussions about the disease in 1986.

In contrary Senegal and Uganda as early as 1986 and 1987 adopted a different approach, they acknowledged, accepted and started the prevention and control programs as early as 1986 and 1987. The politics associated with HIV/AIDS did contribute effective or negatively on the spread or decrease of HIV/AIDS in Africa. These politics also impacted on medical care and innovation, the more the state deny the fact about HIV/AIDS the more it become retarded in terms of prevention and cure. The policies of the nation impacted on innovation and creativity to fight this pandemic, medical officers and scientists are encouraged and motivated by the policy of the nation. In the next section the aims of this research study will be discussed.

AIMS OF THIS STUDY

The aims of this article is fivefolded: Firstly is to briefly, trace the background and

politics of HIV/AIDS in Africa as well as their impact or delay on medical and psychological innovations. Secondly, to describe the research method employed in this article. The investigative centre is Agisanang in Sannieshof in the North-West Province in South Africa. Thirdly, to identify the different approaches to HIV/AIDS by these country. Fourthly, the article aims on identifying the internal messages behind voicelessness of the people infected by HIV/AIDS, which is harmful to the life of the infected and affected by HIV/AIDS. The fifth aim is the employment of narrative approach to externalized, de-construct and to give an alternative message to the infected and affected people. The aims of this research study are the determiners of the research method to use in this article.

RESEARCH METHOD

The research method that is followed in this article is qualitative research where literature review and observation will be employed to collect data needed to draw a conclusion in this research study.

Literature study and Observation

In a review of literature, study of secondary sources has been made with a view to gather information on the messages hidden behind the voicelessness of people infected by HIV/AIDS with special reference to narrative approach. Literature were selected from the range of books, journal articles on HIV/AIDS and narrative counselling. The literature was selected using the following key words: HIV/AIDS; Counselling; Narrative counselling; internalization and externatization.

In this research study, observation was used to collect data on the voicelessness of people infected by HIV/AIDS. Briggs and Coleman (2007:237) regards observation as the most powerful, flexible, and 'real' data collection strategy because is not dependent, like survey, on the respondent's personal views but seeks explicit evidence through the eyes of the observer directly or through a camera lens. It is a holistic approach concerning the observation of 'everyday' events and the description and construction of meaning.

This research method was chosen specifically for the approach used in this article narrative approach that seeks to construct alternative stories out the problem-saturated stories. There was no interview or questionnaire used to collect data, hence ther researcher will not present any statistics in this article.

REACTION OF HEADS OF STATES IMPACT ON HIV/AIDS SPREAD IN 1980s

My involvement in Legae Enrichment centre at Agisanang neer Sannieshof in the North West Province South Africa, has challenged me to struggle to understand why people are internatizing or keeping HIV/AIDS private and confidential. Through my struggle to found the answer to this question I then lay hand on the book by Amy Patterson, "The politics of AIDS in Africa". It is from this book that I have learnt that, African heads of states have responded differently to HIV/AIDS. The majority of them as stated, in the background have keep this challenge as a private and confidential.

Patterson (2006:4-5) provide statics on the spread of HIV in Africa during the period of 1970 to 1980s. He indicates that, most of the available epidemiological data indicate that the extensive spread of HIV started in sub-Saharan Africa in the late 1970s. In the early 1980s, HIV was found in a geographic area stretching from West Africa across to the Indian Ocean, the countries north of the Sahara and those in the southern cone of the continent remained apparently untouched by HIV. In 1987, the epidemic began gradually to move south. Some of the most explosive epidemics have been seen South Africa has the largest number of people living with HIV/AIDS in the world, 5 million South Africans. Furthermore, Botswana and Swaziland have the highest prevalence levels, 38% and 33% respectively (Patterson, 2006:4-5).

West Africa has been relatively less affected by HIV infection than other regions of sub-Saharan Africa. Uganda and Senegal represent two success stories as is mentioned in the background of this article. According to Patterson, Uganda has reduced estimated prevalence to the rate of 5 per cent by the end of 2001 from the rate 14 per cent in the early 1990. The HIV prevalence has stabilized in Senegal at a relatively low level (Patterson, 2006:4-5).

The responses of the heads of the states in Africa had a corollation to the growth of HIV/AIDS in Africa. The countries used in this articles are the example of this corollation. Some of the head of states were arguing from their political, cultural, economic and racial, as the defense mechanism to deny that there is a problem of HIV/AIDS. Each an every political statement from the head of the state has the impact on the people of that state. The denial of the head of the states has contributed to the denial of the people infected by HIV/AIDS.

Swaziland is rated amongst the most affected by HIV/AIDS due to the fact that the head of the state was in denial that polygamy has the effect on the spread of HIV/AIDS. According to United Press International of 2th April 2003 King Mswati said: " HIV/AIDS is promoted by an individual in the manner be or she goes about with his or her life. Otherwise, polygamy is not a factor." Based on the statement argument he is defending the tradition in the face of AIDS, in the meantime the virus was spreading throughout the country. The same attitude prevail in South Africa through the mouth of the well respected African intellectual President Thabo Mbeki in the Prospect of 21th February 2002 saying: " Whether I would take an HIV test or not, I think is irrelevant to the matter." This statement influences the public, because it is from a respected African intellectual, when he distanced himself from AIDS then the public will follow his steps, hence Swaziland and South Africa had delay to tackle HIV/AIDS and has experience high rate of infected people. Uganda is listed amongst the very few country that was successful to address the HIV/AIDS challenge at a very early stage, due to the positive attitude of Ugandian President. Museveni states in his national speech on World AIDS Day, December 1, 2003: " Here in Uganda we gave HIV/AIDS a face because a faceless enemy is very dangerous enemy. Denial and concealment, we realized, would not get rid of the disease, but only make it worse (Patterson, 2006:21). Base on reactions of these head of states there is a tendency that, where the head of state deny or rationalized the existence of HIV/AIDS the disease spread at a rapid speed, while the acceptance decrease the speed of HIV/AIDS spread. The Ugandian president in his speech he introduce the narrative approach by emphasizing the naming, personification and externatization of the problem (enemy).

STIGMA AND DISCRIMINATION ATTACHED TO HIV/AIDS

The reaction of the heads of states in Africa has created the ideology that lead to stigma and discrimination of the people living with HIV/AIDS. Accroding Kalichman and Simbayi (2004) HIV/AIDS is always accompanied by stigma within different societies across countries. In some segments of South African society, AIDS-related stigmas are pervasive. They disrupt the promotion of voluntary counseling, testing, declaring their status and other prevention effects of the disease. The stigmas are reasons for the message that is behind the

voicelessness of the people infected and affected by HIV/AIDS. Even well informed and educated professionals have been shown to concealed AIDS stigmas. These believers are all too willing to endorse social sanctions against HIV/AIDS sufferers (Kalichman and Simbayi 2004). The roots of stigma lie in the logic of basic survival, not the logic of compassion. When people have sufficient resources, they feel compassionate towards the sick, dying, elderly and disadvantaged members of the society, but when tough times arrive, they see them as a burden. Humans may be prepared to sacrifice the afflicted ones to ensure survival of the group.

The argument that AIDS equals death is to focus on fear instead on a desired future. Stigmatization is one of the reasons why people living with HIV/AIDS choose not to disclose their status. Experienced, observed, and feared stigma discourages people from getting tested or from disclosing their status, and this discrimination places an immerse burden on their families, friends, and caregivers. Stigma may make it less likely that individuals, regardless of their serostatus, will join AIDS organizations or play an active role in them. Few brave people infected by HIV/AIDS approached me as Faith leader and faith consultant in Agisanang near Sannieshof in the North-West in 2009 with the intention to establish the HIV/AIDS support group to my disappointment the group could not exist due to the fear of the stigma. It was to my surprise that, when I have left Agisanang for University of South Africa as Senior lecture the organization as established with my assistance being far from the community.

Klinken (2008) indicates that, the initial theological reticence on the epidemic was, because of the association of HIV with controversial sexual behavior, such as homosexuality and promiscuity. In faith communities, often HIV and AIDS were believed to be a punishment from God for immoral behavior. These assumptions created an atmosphere of denial and stigma, in which HIV/AIDS became a taboo issue.

In this sense, the religious beliefs impact negatively on people infected and affected by HIV/AIDS, in this sense voiceless messages are created in the sub-consciousness mind of these people. Beliefs and patterns of behavior rooted in a lack of scientific information, or in misinformation, in knowing things that are not actually true-in myth, other words can be very powerful (Strassberg 2003). This compounded when lack of scientific knowledge and information become twisted with powerful religious beliefs curtailing either from the narrow

interpretation of sacred texts and oral traditions or from the deliberate misinterpretation of such texts and traditions. Some people have internalized the traditional religious teaching that promotes the view that HIV/AIDS is in itself sinful, that it is a curse and an expression of the wrath of God (Strassberg 2003). This view is found among health professionals too, and often leads to emotional barriers in communication and lead infected people to be voiceless. Not only is this judgmental attitude in itself unethical, but also the barrier it establishes and creates a division that fosters stigmatization.

However, due to the high levels of stigmatization of people living with HIV, and wide misunderstanding of the disease, disclosure of an HIV-positive status is made very difficult for some people, perhaps harder than informing people about infections with other viruses or diseases. Interviews examining problems faced by HIV-positive schoolchildren in Namibia and Tanzania revealed it was often parents and care-givers who forbade children from disclosing their status as a way to protect them. This was seen as a consequence of an environment that offers no incentive to disclose.

THE MESSAGES BEHIND VOICES-LESSNESS OF PEOPLE INFECTED BY HIV/AIDS

In this article message behind voicelessness of the people infected by HIV/AIDS are categorized into a foursome pattern of God (spiritual), oneself (emotional), another human being (social) and natural-organic environment (environment). These foursome pattern messages are interconnected and are not easily revealed by the person infected by HIV/AIDS.

Spirituality message behind the voice-lessness (God connection)

The spiritual message behind the voicelessness of people infected and affected by HIV/AIDS is compounded when lack of scientific knowledge and information become entwined with powerful doctrinal beliefs stemming either from the narrow interpretation of sacred texts and oral traditions or from deliberate misinterpretation of such texts and traditions. As already states above, some believers have internalized doctrinal teachings that promote the view that HIV/AIDS in itself is sinful, that it is a curse and an expression of the wrath of God (Pera and Van Tonder 2005). This mentality creates a strong separation within the

individual and eventually disconnects the individual from other human beings and from God.

One cannot adapt oneself to this without the ability to be acquiescent. An inability to reconcile oneself to the effects of suffering and pain often causes bitterness. It is accompanied by spiritual struggle, a search for meaning-the inevitable question: Why me? Is God involved in my sickness and in what way? Why did he let it happen? To what purpose is this happening to me? The spiritual message is always very difficult to reveal, the bearer of this message will struggle with these questions internally without communicating them to anyone. De La Porte (2003) indicates: When your world falls apart and the last piece of security crumbles, it may feel as though God has turned against you. A person may even come to believe that God is planning to punish him/her and even to destroy him/her. Sometimes God may feel distant, detached and cold. You may doubt that he is involved with you. Maybe God is like computer programmer sitting in heaven behind his keyboard and controlling people's lives. Or is he like a strict teacher who is only out to catch us when we do something wrong? The ultimate consequence of this way of thinking is that God is a despot and sadist. The person may feel that he/she deserves the punishment of God for leading a wrong life or committing an unforgivable sin. The extremity of this kind of reasoning culminates in a lack of faith and rejection of God.

The feeling of disconnection from God brings about shame to the person that is affected by this feeling; therefore he/she will be ashamed to reveal this message. The disconnection of this person with God disturbs the intra-relationship (internal peace of mind) and interrelationship (socialization with other human beings) eventually these disconnections make these people voiceless. Fearing the stigma of being called a sinner or an outcast based on the hard doctrinal belief amongst faith communities and entire society forced this people to withhold these messages that are hampering their wellbeing and health. It is also important to look into oneself and intra-connectedness of the individual as well as self-communication.

The secret is out, even faithful people get infected by HIV/AIDS. Unfortunately, religious people often feel that they must hide their pain and pretend that nothing is wrong. This act in itself can make their condition much worse and more difficult to disclose their status. The faithful member of a church start to absent him/herself from the church

services, the sense of belonging is gradually decreasing. The fellow church members fail to read this message and at the end of the journey the church will receive the message that its member is very sick and the family now starts to ask for prayers to prepare the person infected for hism or her death.

The converse is that, an aged long disappeared member will be starting to attend the church services regularly and paying his/her tithes faithfully. This person will not disclose his/her HIV/AIDS and the fellow church members will also fail to interpret the message behind this voicelessness of this person. It is very important to read the signs within the voicelessness, hence the narrative approach is followed in this article to re-author the story of the people infected by HIV/AIDS.

Emotional message behind the voice-lessness (oneself connection)

Disclosing one's status to partners, families, friends, colleagues and health workers can be an incredibly tough and emotional experience, and something which people without HIV would probably not fully comprehend. Issues may differ depending on who is being told, but it is likely that people will be deeply anxious about how the other person will react and they will not want to cause them unnecessary worry.

The feeling of denial is the first message that is hind inside the voicelessness of the person infected; it is hard to accept that it has happened to him/her. This person will be living with this false pretext that they are bewitched. In most cases the traditional healers are consulted to ease this feeling of denial. The person force to live his/her life as if there is nothing wrong with his/her life. I have observed one young man whom, I was his pastor and mentor changing his life drastically. Unfortunately for me, I did not read the message of denial behind this change of lifestyle, until his health deteriorated unto death and it was then that I could realize that the young had suffered a state of denial of being infected by HIV/AIDS. This message was difficult to be read by the by-standers in his or her life.

Anger as a message hidden behind HIV/AIDS

The person infected by HIV/AIDS normally feels angry for him/herself and the people he/she was associating with during his/her life before he/she was infected. Anger is a very common emotion that persons affected with HIV can feel. Feelings of frustration, loss of control and being upset about having a disease that have such a social

stigma attached to it are very normal. Many might feel the situation is unfair and ask, "Why me?" Anger sometimes can lead to depression. It is important for people with anger to talk about how they are feeling and try to redirect this emotion in a positive way. Unfortunately, these people choose not to disclose what make them angry or disclose their health status due to the stigma attached to this pandemic. Hence the narrative approach will be used to externalize the internal messages that could not come to the surface (John, Bartlett, and Finkbeiner; 2006).

Fatigue as a message hidden behind HIV/AIDS

According to John, Bartlett, and Finkbeiner (2006) the person infected by HIV/AIDS has a lot of things in mind that disturbs his or her thinking or there is a lot of thinking around the virus. The spiritual questions as well as emotional questions challenge this person to use lots of energy facing problems that he/she is not in a position to reveal. This behavior creates a state of fatigue in this person. Fatigue and tiredness can come from the physical effects of the disease, the medication side effects and all of the different changes in life that this disease might bring. This can result in changes in how the person socializes, works at their job and interacts with family and friends. Fatigue can be physical or psychological, or both. Depending on the reason for fatigue, the affected person should discuss it with their doctor or someone they can talk to such as a counselor, but in the case of people infected by HIV/AIDS it is not that easy because of the stigma attached to HIV/AIDS.

The result of fatigue is absenteeism and poor performance at work. The person will be asking for permission to go to the doctor for different reasons. The colleagues in most cases could not read the message behind this voicelessness of this person. Fatigue in itself communicates to the other human beings about the situation of their neighbor/colleague.

Grief and Depression as a message hidden behind HIV/AIDS

Grief is a very normal reaction to receiving a diagnosis like HIV. One might feel like getting the diagnosis is a big loss in their life. Persons with depression can feel hopeless and alone. They feel tired and uninterested. There are varying degrees of depression, and sometimes grief can be overwhelming. It is important that if you or a loved one with HIV feels depressed that you

get help from a doctor or a psychologist. Often, HIV caseworkers have many contacts in the community who can help. It is important that anyone with symptoms of depression seek help by communicating with someone they trust and talking to a doctor (John, Bartlett, and Finkbeiner; 2006).

Guilt as a message hidden behind HIV/AIDS

Persons infected with HIV may feel a lot of guilt about how they might have put themselves or others at risk for this disease. Some might feel it is a punishment for bad behavior that they engaged in the past. Others may feel guilty for depending on others. It is important that persons feeling guilt try to understand their self-worth and try to free themselves from the burden of this guilt. Talking about it with someone they trust, joining a support group or talking to others who are affected can sometimes help. It is not unusual for people to blame themselves for illness and to feel it is punishment. This guilt can be worsened by society's prejudice and ignorance about HIV and AIDS. It is important, if you are HIV positive, to seek out those who are accepting and supportive (John, Bartlett, and Finkbeiner; 2006).

Anxiety, Fear and Uncertainty as a message hidden behind HIV/AIDS

Infected persons are normally in fear because they have to adjust to a new lifestyle. It is not easy to accept that one is infected and thus shock and disbelief, leading to denial, is a frequent initial response. According to Watstein and Chandler (1998) there are emotional responses that are symptoms of the psychological effects that people have when infected or affected with HIV/AIDS. Infected persons may be confronted with having to reexamine their sexual identity and the behavioral choices they have made in support of that identity. When one associates HIV/AIDS with what society has traditionally considered immoral, the infected person then has to work through his/her feelings in order for his/her sexual identity to be reaffirmed in a way that will allow for feeling good about oneself.

Fear is another common emotion that persons with HIV or AIDS might have. Fear of the unknown, fear of being rejected and fear of being out of control are all common feelings one might have with a serious illness like HIV. Uncertainty is linked to all of the emotions that go along with getting a diagnosis like HIV. There is uncertainty about one's health, about the future, about the medications and about the experience one

might have with the illness. In some cases, fears of a negative response to disclosure may not be borne out by reality.

It is important to turn this fear and uncertainty into control by learning about the disease, treatments and what to expect. There are many ways to deal with anxiety and stress such as joining a support group, talking to someone or doing relaxation exercises. If nothing helps, it is important to talk to your counselor. In this instance, narrative approach is the way that is highly recommended to deal with anxiety and stress since it separate the problem from a person.

The Social message behind the voicelessness (interconnectedness)

Persons infected by HIV/AIDS may be caused to see themselves as undesirable by others who view them as "contagious". This in itself is an emotional situation that can cause infected people to social withdraw from other human beings, does not disclose their feelings, and become socially isolated. Inevitably, this may lead to an emotional breakdown because these feelings continue to be suppressed. The most destructive stressor in this situation of the person infected by HIV/AIDS is that of feeling isolated. This isolation can have many causes, including the loss of support by lovers, family, and friends. Additional feelings of isolation may result from the need to change their sexual practices and take more precautions to protect themselves and others.

Watstein and Chandler (1998) continue to explain that another destructive stressor is that of feeling dependent. The dependency occurs when the infected person must rely heavily on family and friends for emotional and financial support, particularly when they have to apply for social services assistance. Furthermore, within Namibia an infected person is not granted an opportunity to gain access to life insurance policies. This also can be very frustrating and demoralizing. The final aspect of dependence is the fear of a protracted illness that will drain the family and friends both financially and emotionally.

NARRATIVE APPROACH AS A TOOL TO ASSIST DISCLOSING MESSAGE BEHIND VOICELESSNESS

Morgan (2000) ponders that, when one hears someone refer to the narrative approach, they might be referring to particular ways of understanding people identities. Alternatively, they might be referring to certain ways of understanding problems and their effects on people's lives. They might also be speaking about particular ways of talking with people about their lives

and problems they may be experiencing, or particular ways of understanding therapeutic relationships and the ethics or politics of therapy.

The narrative approach seeks to be a respectful, non-blaming approach to counseling and community work, which centres people as the experts in their own lives. It views problems as separate from people and assumes people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives. The narrative approach forces people to firstly listen to the stories of people struggling in real situations. It does not merely describe a general context, but to be confronted with a specific and concrete situation (Morgan, 2000 and Muller, 2003).

According to Landman (2007) narrative counseling is practiced as a meet process in which the clients' problem-saturated stories are mapped and their problems externalized; they are empowered through the deconstruction of religious or social problem discourses, and their alternative stories are thickened by means of social or religious practices. Freedman and Combs (1996) describe: *Narrative therapists are interested in working with people to bring forth and thicken stories that do not support or sustain problems. As people begin to inhabit and live out the alternative stories, the results are beyond solving problems. Within the new stories people live out new self images, new possibilities for relationship and new futures.* To be freed from the influence of problematic stories, it is not enough to simply re-author an alternative story. Narrative therapists are interested in finding ways in which these alternative stories can be 'richly described'. The opposite of a 'thin conclusion' is understood by narrative therapists to be 'rich description' of live and relationships. It is very important to have understood the overview of narrative approach before one can implement it in assisting people who are infected by HIV/AIDs and at the same time they have a hidden message behind their health situation.

Understanding and living lives through stories

According to Morgan (2000) human beings are interpreting beings. Human beings have daily experiences of events that we seek to make meaningful. The stories they have about their lives are created through linking certain events together in a particular sequence across a time period and finding ways of explaining or making sense of them. This meaning forms the plot of the story.

Human beings give meaning to their experiences constantly as they live their lives. Narrative is like a thread that weaves the events together, forming a story. People have many stories about their lives and relationships, occurring at the same time. For example, they have stories about themselves, their abilities, their struggles, their actions, their desires, their relationships, their work, their interests, their conquests, their achievements, their failures. The way they have developed these stories is determined by how they have linked certain events together in a sequence and with the meaning they have attributed to them.

What Morgan (2000) has mentioned above is the case of most people infected by HIV/AIDS. During my interview with the Aganang HIV/AIDS support group of Agisanang in Sannieshof in Tswaing municipality in the North -West interviewees would tell me many different stories of their past, present and future. They would emphasize the problem-saturated stories about their present and future lives, how their HIV/AIDS situation has impacted their lives negatively so. In most cases these stories are hidden, are not told to anybody because these clients drawn a *thin conclusions* about themselves.

Morgan (2000) contends: Once thin conclusions take hold, it becomes very easy for people to engage in gathering evidence to support these dominant problem-saturated stories. The influence of these problematic stories can then become bigger and bigger. In the process, any times when the person has escaped the effects of the problem, any times when they have not been 'bad', 'hopeless' or 'a trouble maker' become less visible. As the problem story gets bigger and bigger it becomes more powerful and will affect future events. Thin conclusions often lead to more thin conclusions as people's skills; knowledge's, abilities and competencies become hidden by the problem story.

In this article these thin conclusions are within the messages that are hidden behind the voicelessness of people infected by HIV/AIDS that need to be thickening through the narrative approach in re-authoring an alternative story.

According to Narrative approach, when initially faced with seemingly overwhelming thin conclusions and problem stories, caregivers are interested in conversations that seek out alternative stories – not just any alternative stories, but stories that are identified by the person seeking help as stories by which they would like to live their lives. The caregiver is interested to seek

out, and create in conversations, stories of identity that will assist people to break from the influence of the problems they are facing and reveal the problem stories that will the re-authored into alternative stories (Morgan 2000). Just as various thin descriptions and conclusions can support and sustain problems, alternative stories can reduce the influence of problems and create new possibilities for living that will empower, give hope, strength and encourage the clients to be function again.

Towards rich and thick description of messages behind voicelessness of people infected by HIV

People infected by HIV they normally focus on the thin description that lead them to thin conclusion based on the stigma and discrimination attached to HIV/AIDs. In narrative approach the problem-saturated stories or the thin conclusion is a point of departure towards enriching and thickening of these thin conclusion in such a way that a caregiver or therapist together with the client they will come up with an alternative stories. In this section I will briefly discuss how to enrich and thicken the thin conclusions of people infected by HIV/AIDS.

The people infected by HIV to be freed from the influence of problematic stories of HIV/AIDs hidden behind their voicelessness, it is not enough to simply re-author an alternative story of one's life of hope behind HIV/AIDS pandemic. In narrative approach the interest is in finding ways in which these alternative stories can be 'richly described'. The opposite of a 'thin conclusion' is understood in narrative approach as a 'rich description' of lives and relationships. Many different things can contribute to alternative stories being 'richly described' – not least of which being that they are generated by the person whose life is being talked about. Rich description involves the articulation in fine detail of the story-lines of a person's life. If you imagine reading a novel, sometimes a story is richly described – the motives of the characters, their histories, and own understandings are finely articulated. The stories of the characters' lives are interwoven with the stories of other people and events. Similarly, narrative approach is interested in finding ways for the alternative stories of people's lives to be richly described and interwoven with the stories of others (Morgan 2000).

When one reads the stories of three African leaders, namely King Mswati III; Thabo Mbeki and Yoweri Museveni cited by Patterson (2006) concerning HIV/AIDS one could see reflections of 'thin conclusions'

and the 'rich description' of the story about HIV/AIDS from these leaders' perspective. In this article I will focus on Mswati and Museveni' quotations for a better comparison on 'thin conclusion' and 'thick description'. In 2003 King Mswati III of Swaziland once said that, HIV/AIDS is promoted by an individual in the manner he or she goes about with his or her life. Otherwise, polygamy is not a factor. In King Mswati III's story it is more blame and defensive on traditional aspect, it is a 'thin conclusion' as compared to the one made by Yoweri Museveni in 2003 when he said: "Here in Uganda…we gave HIV/AIDS a face because a faceless enemy is a very dangerous enemy. Denial and concealment, we realized, would not get rid of the disease, but only make it worse." Patterson (2006) states: These quotes highlight different approaches to AIDS among African leaders, from Mswati's defense of tradition in the face of AIDS, to Mbeki's distancing himself from HIV, to Museveni's desire to tackle the AIDS stigma." Museveni try to name the problem and he enriches and thickens the story of HIV/AIDS in order to come up with an alternative story to address the problem of HIV/AIDS in Uganda. In his approach he externalized the problem by giving the problem a face; in narrative approach he is naming the problem so that the Ugandan must separate the problem (HIV/AIDS) from the person.

The ways in which alternative stories are co-authored, how they are told and to whom, are all relevant considerations for narrative therapists. In the following paragraph, ways to co-author conversations that engage people in the 'rich description' of their lives and relationships will be more fully explored in relation to assistance of people infected by HIV/AIDS's hidden messages behind their voicelessness.

Externalizing message hidden behind voicelessness of the people infected by HIV

Externalising conversations is only the beginning of the journey to solving the client's problem. It allows the space needed to examine and evaluate. Once the client is no longer entrenched and identified with the problem, they can step back to examine and evaluate the effects of the problem and begin to identify alternatives for their life (White, 2007). Externalizing conversations reverse the common logic in psychology that focuses explanations for events inside the person, the way that person internally thinking about him/herself in relation to HIV/AIDS. It emphasizes the relational domain and the world of discourse as an origin for

experience. As clients externalize a conflict, they speak about it as if it was an external object exerting an influence on the parties but not identified solely with either party. Externalizing introduces a way of speaking about the problem (HIV/AIDS) that interrupts blame and guilt and assists the parties to dis-identify with the problem itself. It promotes a clear separation between people and problems and then invites a re-evaluation of their relationship with problems (White and Epston, 1992; Epston and White 1992 or White and Epston, 1990, Winslade and Monk, 2000).

Clients and therapists often experience externalizing conversation as lightening of the heaviness of the problem. Blame and its counterparts, guilt and shame, can be thought of as hindrances to the finding of a way forward in problem situations. The humanistic assumption of encouraging people to take responsibility for their part in producing the problem fails to obviate this heaviness. By contrast, an externalizing way of speaking can rapidly give the clients a different experience of the problem they have been living with like HIV/AIDS. The power and authority of habitual ways of thinking about the problems are destabilized. In a sense the messages that are behind the voicelessness of the people infected by HIV/AIDS are destabilized. The greatest challenge for these people is how to externalize these deeply rooted messages behind HIV/AIDS.

One of the first things that narrative approach is interested in doing is to separate the person's identity from the problem for which they seek assistance. Clients and therapists begin speaking about the problem in ways that situate it separately from the person and their identity. This is based on the premises that the problem is the problem, as opposed to the person being seen as the problem. Externalization requires a particular shift in the use of language. It is an attitude and orientation in conversations, not simply a technique or skill (Morgan 2000). During externalization in this article I will focus on the 'naming the problem' and 'what can be externalized based on messages that are hidden behind people infected by HIV/AIDS.

Naming the problem

An "externalizing" emphasis, such as by naming a problem so that a person can assess its effects in his life, come to know how it operates or works in his life, relate his earliest history, evaluate it to take a definite position on its presence, and in the end choose his relationship to it. Furthermore, it is of paramount important that the consulting

client should come up with the language and name for the problem and is selected by the client. Naming the problem is the task of the client not the therapist! This task is critical because naming implies power and authority for those who feel that are disempowered by their present difficulties. There must be a helpful list of ways to introduce this naming by the client. For example, 'What name would you give to what you are going through at the present time?' 'It sounds to me like you've been emotionally hurt. What name would you like to give to what has happened to you?'

When encouraging the person to expand her initial narrative, the therapist invites her to give a specific name or names to the problem, perhaps a single word or short phrase. If the person cannot think of a name the therapist floats possibilities, such as 'depression', 'stress in the marriage', 'abuse' and so on, until a name is provisionally agreed. This name is then used, unless further description by the person suggests that a different, more precise name might be appropriate, when another name is chosen. Naming encourages focus and precision, enables the person to feel more in control of the problem and gives a precise definition for the externalization of the problem (Payne 2006).

In this sense the messages that are hidden behind the voicelessness of the people infected by HIV/AIDS need to be named in order for the client to externalize the messages that are internalized and to separate the problem from themselves. All key messages mentioned in section 4 needs to be named for example the emotional ones like fear of death, guilt, anger for oneself and other people they all need names in order for the client to be empowered and to have control over the problem.

What can be externalized?

Morgan (2000) mentioned what can be externalized as follows:

Feelings

Feelings such as anxiety, worry, fear, guilt, depression may be the focus of externalizing conversations. In these situations, the therapists in the narrative therapy might phrase their questions like these:

- *So what has the Guilt tried to talk you into about yourself?*
- *So how has the fear tried to convince you that it is unsafe to go out of your own house?*
- *How long has the anger been trying to get between you and your friends?*

Problems between people

Aspects of interpersonal relationships may also be externalized, for example the bickering, the blame, the criticism, the fighting, the hopeless, the mistrust, the jealousy. Questions in these situations could sound like:

- *What have the fights, talked you into about yourself as a partner?*
- *What does the blame have you doing with each other?*

Cultural and social practices

Cultural and social practices may also be situated away from the person. Mother-blaming, parent-blaming, women-blaming, heterosexual dominance, racism, economic rationalism may be named as practices that have assisted the problem to increase its influence in a person's life. For example the person infected by HIV/AIDS will be rationalizing about his/her economic situation if he/she can loss his/her job due to ill-health caused by the HIV.

Other metaphors

Sometimes people may talk about a problem metaphorically. For example, they may speak of a 'wall of resentment', 'the block', 'and the dream', or 'the tidal wave of despair'. Metaphors like these can also be externalized. Moreover, in the situation of the people infected by HIV/AIDS when people are shy to mention the problem based on its socio-cultural taboo's.

CONCLUSION

The messages behind the voicelessness of people infected by HIV/AIDS were traced and its development from historical and stigmatization. In the 21th century, this researcher contributes to academic and health situation through the utilization of narrative approach in assisting people infected by HIV/AIDS to externalize these messages that are harmful to their positive health and wellbeing.

To argue that AIDS equals death is to focus on the 'thin description' instead of on the 'thick description' of a desired future. If these people focus on the thick description Life will be valued, protected and respected when people living with HIV/AIDS have a reason to live and contribute to society. The expression *'living with HIV/AIDS'* is more positive than '*AIDS victim',* and inspires a person to engage in a productive life which will in turn reduce stigma. Emphasis on quantity of life will enhance quality of life and has more benefits for everyone than stigma-based behaviour.

Through externalization of the messages behind voicelessness of people infected by HIV/AIDS these people will no more be victims of HIV/AIDS but people living with HIV/AIDS. This expression 'people living with HIV/AIDS' illustrate separation of the person from the problem. The work presented the type of approach that need to reveal these messages and what need to be externalized when following this approach.

CONFLICT OF INTREST

There is no conflict of interest.

BIBLIOGRAPHY

BARTLETT, J.G, and FINKBEINER, A. K. 2006. The Guide to Living With HIV Infection (6th ed.). London: Routledge.

BRIGGS, A., R., J., and COLEMAN, M. 2007. Research Methods in educational leadership and management (2nd ed.). London; SAGE Publications

CHIRWA, W.C. 1998. Aliens and AIDS in Southern Africa: The Malawi-South Africa Debate. African Affairs 97 (386): 53-79

COHEN, L., MANION, L. and MORRISON, K. 2007. Research methods in Education

DE LA PORTE, A. and Herbst, A. 2003. Memory work: Telling your story through life maps. Pretoria:CB Powell Bible Centre Unisa

FREEDMA, J. AND COMBS, G. 1996. Narrative therapy: The social construction of preferred realities. New York: Nerton

Fortin, Alfred, 1987. The politics of AIDS in Kenya. Third World Quartly 9 (3): 909-919

KALICHMAN, S.C. AND SIMBAYI, L. 2004. Traditional beliefs about the cause of AIDS and AIDS – related stigma in South Africa. AIDS care. Vol. 16 No.5:572-580.

LANDMAN, C. 2007. *Doing narrative counselling in the context of township spirituality*. DTh Thesis. Pretoria: Unisa.

LEEDY, P. D. & ORMROD, J.E. 2001. Practical Research: Planning and design. New Jersey: Prentice Hall.

MORGAN, A. 2000. What is narrative therapy: An easy-to-read introduction? Adelaide South Australia: Dulwich centre Publications

MULLER, J.C. 2003. Companions on the Journey. Johannesburg: Logos Electronic Publishers

PATTERSON, A. S. 2006. The politics of AIDS in Africa. London: Lynne Rienner Publishers, Inc

PAYNE, M. 2006. Narrative therapy: Introduction for counselor, 2nd edition. London: Sage Publications

PERA, S.A. and VAN TONDER, S. 2005. *Religious and cultural forces in the*

transcultural nursing. (In Pera, S.A. and S. Van Tonder (Eds) Ethics in health care. 2nd ed. Landsowwe: Juta & Co Ltd. pp.175-198).

STRASSBERG, B. A. 2003. The plague of bood: HIV/AIDS and the ethics of the global health-care challenge. Zygon, 38(1): 169-183

WATSTEIN, S.B. and CHANDLER K. 1998. The AIDS Dictionary. Facts on File, Inc.New York,

WHITE, M. 1989. The externalizing of the problem. Dulwich Centre Newsletter. Special edition. pp. 3-21.

WHITE, M. 1992. Deconstruction and therapy. In D. Epston & M.White (Eds.), Experience, contradiction, narrative, and imagination. Adelaide, Australia: Dulwich Centre Publications.

WHITE, M. 2007 *Maps of Narrative Practice*. New York, NY: W. W. Norton & Company Inc. Article Source: http://EzineArticles.com/3247046

WHITE, M. AND EPSTON, D. 1990. Narrative means to therapeutic ends. New York: Norton.

WINSLADE, J., and MONK, G. 2000. Narrative mediation: A new approach to conflict resolution. San Francisco: Jossey-Bass