NORTHWESTERN THEOLOGICAL SEMINARY

Pastoral counseling to young people who are born with

HIV/AIDS

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MASTER IN THEOLOGY

IN

CHRISTIAN COUNSELING

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Certification

I, the undersigned, do certify that the content of this thesis is my own original work and has not been previously submitted to any other University or Institution of Higher Learning for any academic reward. It is my own research whereby other scholars' writings were cited and references provided.

Byiringiro Samuel

Date September 18th, 2012

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ABSTRACT

The basic premise of this study is that the congregation is the key to providing pastoral counseling to young people who are HIV-positive. In so doing, the church does not only perform a social function to young people who are HIV-positive, but it also acts in accordance with the calling of mediating God's Kingdom*(diakonia*) and spreading the gospel, and showing unconditional sacrificial love and compassion. The Church embodies the gospel, which is the instrument of hope and salvation to despairing HIV/AIDS-people in the community

This study attempts to underline pastoral care as a congregational responsibility and not only that of the pastor. The paradigm shift of pastoral ministry from the professional pastor to becoming the responsibility of the whole congregation strengthens the case for pastoral care ministry. The congregation should design pastoral care ministry that functions as an arm of the church in providing support to families and homes affected by HIV/AIDS. It is presupposed in this study that it has been said, preached and written that the church should be involved in HIV/AIDS care and counseling, which is the support function being advocated in this research, but many Christians are still not involved. Among the reasons for this failure is that there is no proper training on Pastoral care ministry to those people who are HIV/AIDS positive. It is argued explicitly and implicitly in this study, based on the inclusive nature of the pastoral care function, that the whole congregation should be involved in loving and providing care (support) for HIV/AIDS-infected young people in the community. The suggested practical way to do this is to begin a pastoral counseling ministry. The proposed model is simply called ***"Pastoral counseling to young people who are HIV/AIDS positive".***

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CHAPTER 1: INTRODUCTION

1.1 THE RESEARCH PROBLEM

1.1 Problem identification

The following questions help to focus the research programme:

• In terms of crisis management, how can pastoral care play a role in providing a support system to young people who are HIV-positive, especially during the crisis stage?

• How can the concept of Pastoral care ministry be applied to a model in which the congregation becomes a caring community, reaching out to the needs of HIV-positive young people without the luxury of a sophisticated medical care system.

1.2 Hypothesis

In order to provide a support system to people suffering from HIV/AIDS, the pastoral ministry should move away from a very sophisticated counseling room approach to a congregational systems approach, which is focused not only on the congregation but also on the needs, pain and suffering of the community and society.

Through designing an HIV/AIDS pastoral care ministry, the congregation (*koinonia* of believers) could reach out and provide support to the infected people (enfleshment of *agape*), which is the calling of the church. In so doing, the church does not only perform a social function to HIV/AIDS-infected people, but it also acts in accordance with the calling of mediating God's Kingdom. Thus, spreading the gospel (Word and deed), showing unconditional sacrificial love and compassion, which is enfleshment or embodiment of the gospel. The identification with the suffering of the young person dying of HIV/AIDS should be viewed as instrumental to pastoral care and the enactment of salvation, which is the impetus of hope.

1.3 The goal of the research

The research aims to investigate how HIV/AIDS pastoral care and counseling within a congregation can effectively be done to provide a support structure for people who are HIV/AIDS positive. This is research will be much focus to those vulnerable young people who are born with HIV-positive.

1.4 Research methodology

1. The research will be a literature study. Enough sources have been found on the issue of Church, HIV/AIDS and HIV/AIDS infected people.

2. The method of critical reflection as well as analysis and logical arguments will be applied in order to understand the pandemic.

3. A hermeneutical approach will be followed in order to gain clarity on the link between the HIV/AIDS pandemic and theology reflection.

4. Indirectly, I will make use of the method of participatory meeting with church leaders, church members and HIV/AIDS infected people especially to those who are born with it. All these will be happening through home visitations, counseling sessions and pastor's meetings.

1.5 Outline of chapters

Chapter 2: A contextual Understanding of HIV/AIDS

Here I will offer HIV/AIDS information; facts on HIV/AIDS issues such as definition and description, origin, infection, transmission and statics; infection progress; factors contributing to the rapid spreading of the epidemic. In general this chapter will give a clear definition of HIV/AIDS and current situation of HIV/AIDS infected people especially those who are born with it.

Chapter 3: The interplay between Bible and HIV/AIDS

Having a clear understand about HIV AIDS, it will make me to enter in the Bible and see what Bible says about HIV/AIDS. I will do research and make my analysis on Old Testament and New Testament. I will put my theological reflection on this point. This will be a respond of people who have different view on HIV/AIDS; as some people see HIV/AIDS as curse and punishment of God to the sinners, consequences of sins, and others believe that it is normal sickness.

Chapter 4: The Church Understanding of HIV/AIDS people status

Here I will mention the definition and description of the church; the practical theological nature church. Even though I will talk church as body of Christ but I will put my emphasis to local church, where I will make my research of analysis on this main points; 1. The mission of local church and how local church operates. After I will make my overview of how church today sees HIV/AIDS people status and what local church does to those people who are HIV/AIDS infected within its immediate community.

Chapter 5: Pastoral counseling to people who are born with HIV/AIDS

Having clear understanding of how Church understanding these HIV/AIDS people status. I will pick Pastoral counseling as most effective tool to the church to serve these HIV/AIDS infected people. Here is where I will offer the definition and description of Pastoral counseling, different modes and stages of pastoral counseling, the distinctiveness of pastoral counseling, how can local the whole congregation be involved to pastoral counseling to young people who HV/AIDS are infected within in the congregation and its immediate community. Chapter 6: this chapter is all about Conclusion, discussion and recommendation.

1.6 Possible value of the research

It is envisaged that the product of this research would be a resource to HIV/AIDS caregivers, faith-based NGO programme planners, church leaders and counselors. Furthermore, it would encourage the church to draw from its history and cultures in order to help Christians to develop a practical approach towards those are suffering with being rooted in scripture.

CHAPTER 2: **A CONTEXTUAL UNDERSTANDING OF HIV AND AIDS:**

2.1 ***HIV and AIDS definition and description*****:**

AIDS is the acronym for Acquired Immune Deficiency Syndrome. It is a condition caused by HIV i.e. the Human immunodeficiency virus. The HI virus enters the body from outside (i.e. it is immune system that defends the body against infection. When the body's immunity is weakened, this is called immune deficiency. Because the body no longer has immunity to fight against any infection, it becomes open to any infection. A syndrome therefore "refers to a set or collection of specific signs and symptoms that occur together and that are characteristic of a particular pathological condition" (Van Dyk 2001:4). Rebirth African Art (http://www.rebirth.co.za/AIDS_in_Africa_2.htm 2003:1) simply stated, "HIV and AIDS cause an immune-system breakdown rather than a specific disease, so people can die of any one of dozens of diseases that have been here in Africa for decades". Although AIDS is called a disease, it is important to emphasize that it is not a specific illness, but a collection of many different conditions that manifest in the body because them HI virus has weakened the immune system. The body can no longer fight the pathogens that invade the body. Hence it is more accurate to define AIDS as a syndrome of opportunistic diseases, infections and certain cancers - each or all have the ability to kill the infected person in the final stages.

2.2 HIV infection

The HIV1 is believed to be the cause of infections in Central, East and Southern Africa, North and South America, Europe and the rest of the world. HIV2 was discovered in West Africa (Cape Verde Islands, Guinea-Bissau and Senegal) in 1986 and it is mostly restricted to West Africa (Jackson 2002:145 and Van Dyk 2001:5). Both viruses cause AIDS, but the difference is that HIV2 works slowly on the victim, thereby taking long for the victim to develop AIDS symptoms.

The immune system (i.e. the body's defense mechanism) has several different methods of fighting infections, some of which are the white blood cells, i.e. phagocytes and lymphocytes (T cells and B cells). The T4 or CD4 cells activate other cells to fight against infection in different ways. They also destroy the cells infected with viruses. And it is these (T4 or CD4) cells that are affected by HIV, thereby making them ineffective. In addition, HIV invades dendrite cells that alert the CD4 cells to the presence of the foreign bodies (i.e. infections). When they are destroyed, the response of the CD4 cells will be very weak. The destruction of the immune system means that infections can occur in the body unchallenged and multiply to cause serious diseases. The complexity and unique challenge of HIV rests on its ability to mutate or change rapidly. HIV mutates or changes its outer layer so rapidly that it is extremely difficult to detect any similarity between the outer layers of one HI virus and the next. Because of this rapid

mutation, the body cannot defend itself against the enemy, because its enemy is constantly changing its identity

2.3 HIV and AIDS spreading

There are four body fluids that contain high HIV concentrations in an infected person and show evidence of transmission: blood, semen, vaginal fluid and breast milk. But saliva, tears, perspiration and urine have low HIV concentrations and there is no evidence of transmission. Therefore, transmission focuses on the four highly concentrated fluids that can be passed from the infected person to the next largely through sexual intercourse, blood transfusion, and by way of parent to child (mother to child).

1. ***Sexual intercourse***

HIV infection is mostly transmitted sexually through unprotected vaginal or anal intercourse (without a condom), and possibly but very rarely through oral. HIV is transmitted when the virus enters the blood stream via the body fluids and connects to the CD4 cells. Women are more vulnerable to be infected with the virus due to physiological, anatomical and socio-economic factors, and age.

Statistically, a single unprotected sexual encounter with an infected person is enough for an infection to occur.

2. ***Contaminated blood***

The HI virus can be transmitted when a person receives contaminated blood during blood transfusion and this account for 1% of the HIV cases . However, though there are far fewer cases of HIV transmission through blood transfusion than sexual transmission. Apart from blood transfusion, people who share syringes and needles to inject drugs are also at high risk. UNAIDS 2000 estimated that nine out of ten cases of transmission of HIV among heterosexuals in New York can be traced back to having sex with a drug user who receives drugs intravenously. Needles, syringes and other sharp instruments either in hospitals or used in piercing or cutting such as circumcision, may expose people to the HI virus.

3. ***Parent to Child (i.e. direct mother-to-child)***

Mother-to-child HIV transmission is responsible for HIV cases in young children, and accounts for 13% of the HIV cases. However, mother-to-child transmission (MTCT) is preferably called parent-to-child transmission (PTCT), since the mother might have got the HIV from the spouse. PTCT transmission takes place during pregnancy (approx. 6%), during labour and delivery (approx. 18%) and during breastfeeding (approx. 4%) (Ray *et al.* 2002:21; Christian Aids Bureau 3.4/23). HIV infection can occur in early pregnancy and many of these pregnancies end in miscarriage and stillbirths. But the main pregnancy HIV transmission occurs during the last three months or during labour and delivery. Postnatal HIV infection occurs through breastfeeding. Administering antiretrovirals, e.g. Nevirapine, controls pregnancy transmission; delivery through caesarean operations controls delivery infection; and safer breastfeeding or replacement infant feeding control postnatal infection. However, though PTCT can be reduced, it is

hampered by poor antenatal care because of the poor medical facilities prevalent among the vulnerable poor HIV/AIDS majority.

HIV-positive women who have access to services can also receive advice and support on how to reduce the risk of HIV transmission to their infants after Safer breastfeeding refers to only the mother breastfeeding the infant delivery. Both the benefits of breastfeeding and the risk transmission of HIV through milk are of greatest significance in the first six months of an infant's life. Although avoiding breastfeeding completely is the most effective way to avoid transmission, it carries other risks to infants and complications for mothers. Replacement feeding can be unsafe and expensive, and it increases the risk infectious diseases. *In areas where breastfeeding is the norm, mothers may be under pressure to conform to avoid suspicion and the stigma attached to HIV- positive status.* This can result in mixed feeding (switching between breastfeeding and replacement feeding), which increases the risk of transmission because the infant gut can become damaged and provide entry for HI infection. WHO

2.4 HIV/AIDS: infection and progress

HIV infection progresses through a number of stages until the person eventually dies. However, it is important to explain that these stages are not precisely demarcated into separate and distinct phases with easily identifiable boundaries. It is better to think of the stages as a progression. The stages are: the primary infection phase or acute sero- conversion illness, the asymptomatic latent phase, the minor symptomatic phase, the major symptomatic phase and opportunistic diseases, and AIDS-defining conditions: the severe symptomatic phase.

The primary infection phase or acute sero-conversion illness: The phase begins at the time of infection when the person gets the HIV. After infection a person goes two to six weeks or several months with no signs or symptoms of disease and without detectable antibodies to HIV. An HIV (antibody test) test at this time will be negative. This is called the "window period." Sero-conversion refers to the point when the person's HIV status converts or changes from being HIV negative to positive (antibody test). This normally occurs after four to eight weeks or more of the window period. The person would have flu-like illness, fever-like illness and with sore throat, headache, mild fever, fatigue, rash, and oral ulcers. The person may not visit a doctor because the sickness is mild.

The asymptomatic latent phase: This stage can last from a few months to 10-15 years. The person will not show any signs of infection. The HI virus is present and destroying the immune system, but the person is not aware of and appears healthy and normal. During this time the person may infect many other people. Jackson calls this stage the incubation period.

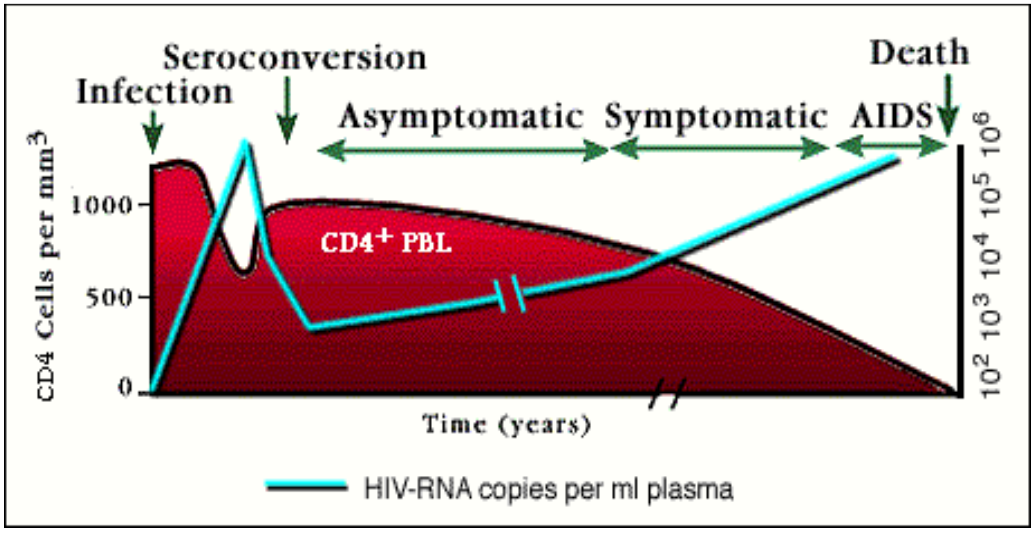
The minor symptomatic phase: At this stage, the early symptoms of HIV disease usually begin to manifest. Jackson calls this stage "HIV/AIDS related illnesses". The immune system is badly depleted and the HIV load has increased greatly. The symptoms include mild to moderate swelling of the lymph nodes in the neck, armpits and groin; occasional fevers; herpes zoster or shingles (which is sign of low immunity); skin rashes, dermatitis, chronic itchy skin, fungal nail infections; recurrent oral ulcerations; recurrent upper respiratory tract infections; weight loss up to 10% of the person's usual body weight; and malaise, fatigue and lethargy.

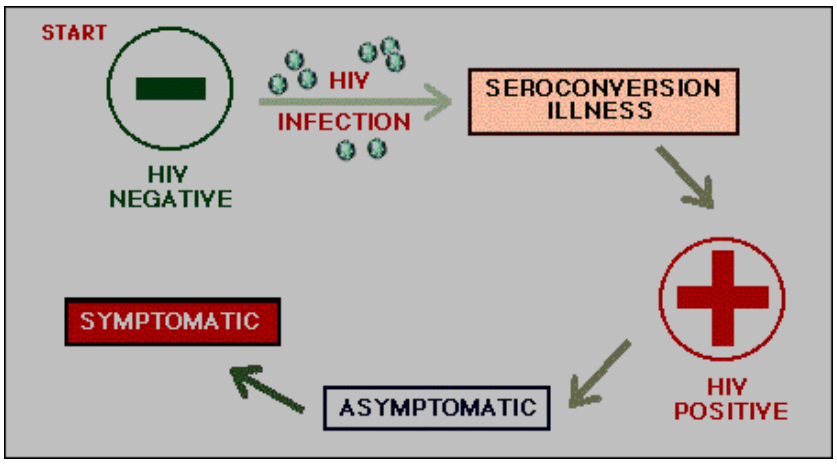
The major symptomatic phase and opportunistic infections: At this stage the opportunistic diseases start to take advantage of the deteriorating immunity. The viral load is very high and the CD4 cells are low. The following symptoms that are signs of immunity deficiency are evident: persistent and recurrent oral and vaginal Candida infections; recurrent herpes infections, such as herpes simplex (cold sores); bacterial skin infections and skin rashes; intermittent or constant unexplained fever that lasts for more than a month; night sweats; persistent and intractable chronic diarrhea that lasts for over a month; significant and unexplained weight loss (more than 10% of normal body weight); abdominal discomfort; headaches; oral hairy leucoplakia (thickened white patches on the side of the tongue); persistent coughing and reactivation of tuberculosis; various opportunistic diseases. At this stage the person is bedridden 50% of the day.

The AIDS-defining conditions - the severe symptomatic phase: At this stage the patient's condition is referred to as "AIDS full-blown" and the body does not respond to antibiotics. These people are confined to their bed and usually die within two years. But in Africa they often die within one year because of the lack of drugs and correct nutrition. The World Health Organization gave the following guidelines for the diagnosis of AIDS in Africa. Major signs: weight loss of more than 10% of body weight; long-lasting diarrhea; long-lasting fever, i.e. for over a month; major signs – persistent cough, over one month; generalized itchy skin disease; recurring shingles (herpes zoster); thrush in the mouth and throat; long-lasting, spreading and severe cold sores (herpes simplex); long-lasting swollen glands (PGL); loss of memory; loss of intellectual capacity; peripheral nerve damage.

The diagrams below show the stages of HIV progression in the body (CD4 cells and immunity weakening)

In the diagram, both minor symptomatic and major symptomatic are under symptomatic





The progression of HIV diseases varies from person to person and depends on a number of factors including genetics, mode of transmission, and attitude to life and adaptation to the HIV status. Though the usual progression is the one denoted by bold arrows, some people jump one stage or return to the previous stage, especially with antiretroviral therapies. However, though the progression takes 8-15 years, in Africa it often takes less than that due to poverty. What is clear, though, is that after sero conversion each person develops a viral load set point. The lower the viral load, the slower the progression of HIV disease (i.e. immune system destruction) and eventually clinical symptoms and opportunistic conditions leading to death. Knowledge of the five stages discussed is invaluable to people in HIV/AIDS support and care. However, at this point we should ask: what are the factors responsible for the vast extent of the epidemic?

2. 5 HIV and AIDS statistics

Global HIV and AIDS estimates, 2009 and 2010

The latest statistics of the global HIV and AIDS epidemic were published by UNAIDS, WHO and UNICEF in November 2011, and refer to the end of 2010.

	Estimate	***Range***
People living with HIV/AIDS in 2010	*34 million*	*31.6-35.2 million*
Proportion of adults living with HIV/AIDS in 2010 who were women (%)	*50million*	*47-53 million*
Children living with HIV/AIDS in 2010	*3.4 million*	*3.0-3.8 million*
People newly infected with HIV in 2010	*2.7 million*	*2.4-2.9 million*
Children newly infected with HIV in 2010	*390,000*	*340,000-450,000*
AIDS deaths in 2010	*1.8 million*	*1.6-1.9 million*

Statistics published by UNAIDS in November 2010, referring to the end of 2009.

	Estimate	***Range***
People living with HIV/AIDS in 2009	*33.3 million*	*31.4-35.3 million*
Adults living with HIV/AIDS in 2009	*30.8 million*	*29.2-32.6 million*
Women living with HIV/AIDS in 2009	*15.9 million*	*14.8-17.2 million*
Children living with HIV/AIDS in 2009	*2.5 million*	*1.6-3.4 million*
People newly infected with HIV in 2009	*2.6 million*	*2.3-2.8 million*
Adults newly infected with HIV in 2009	*2.2 million*	*2.0-2.4 million*
AIDS deaths in 2009	*1.8 million*	*1.6-2.1 million*

Orphans (0-17) due to AIDS in 2009	*16.6 million*	*14.4-18.8 million*

Global trends:

The number of people living with HIV rose from around 8 million in 1990 to 34 million by the end of 2010. The overall growth of the epidemic has stabilised in recent years. The annual number of new HIV infections has steadily declined and due to the significant increase in people receiving antiretroviral therapy, the number of AIDS-related deaths has also declined.

Since the beginning of the epidemic, nearly 30 million people have died from AIDS-related causes.

2.6 Factors influencing the spread of HIV and AIDS .

The reasons why HIV and AIDS is spreading very fast are not absolutely clear. But Jackson (2002:8) and others (Shelp & Sunderland 1987:14; Grenz and Hoffman 1990:75-76) identified nine main risk factors for high HIV transmission rates. She outlined them as: population movement, including the military; developed trade and transport routes; gender inequity and inequality; poverty and unequal distribution of wealth; lack of social cohesion in some areas; broad sexual mixing and multiple partnerships, including commercial sex; various cultural factors (e.g. low rates of male circumcision); high level of untreated sexually transmitted infections and reproductive tract infections; and relatively low condom use (Jackson 2002:8).

Hunter's (2001:12) explanation together with the above factors may probably shed more light to the discussion. She wrote: A number of factors are at work in determining HIV prevalence, including factors particular to the HIV1 virus itself and factors in the human environment in which it finds itself. There is some support for the theory that different clades, or geneticsubtypes, of HIV1 are less virulentthan others . Clad B, Virulence is the power of a virus or bacteria to cause a disease, measured by the number of people its affects, how easily infections occur, how quickly the virus spreads through the body, and how quickly the disease progresses to death.

Part of the reason why HIV statistics are so high in Africa is that the virus has been present far longer in the communities of Africa. The virus originated in Africa, and then spread to other continents, as transport became more freely available and travelling became easier. This is only part of the reason, as infrastructure, migrant labour, poverty, culture, etc., also play a major role in extent of the spread of the virus.

Otherwise, apart from poverty, there could be arguably no satisfying explanation why HIV/AIDS cases are low in the West. However, having considered the factual aspects of HIV and AIDS, it is important to consider how the African people perceive it. Thus the question: how do HIV and AIDS fit into the African worldview (framework) of sickness?

Within the African worldview, sickness is perceived to be personalistically /supernaturally caused. The witches, ancestors, breaking taboos, curses or nature spirits cause it. Human beings are in a continuous relationship with cosmic forces, which influences them. Angry spirits may cause someone to be sick and sacrifices may restore the cosmic balance. Therefore, breaking away from the delicate balance in Africa is risky and it warrants supernatural sanction. Hence within the African conceptual framework, though AIDS may be attributed to naturalistic cause (HIV), there is always a supernatural link. Thus the supernatural forces cause the individual to, in one way or another, engage with an HIV-infected person. Therefore, though there may be no outright denial of naturalistic cause, the supernatural force is the overriding cause that influences the infection.

2.7 Preminary conclusion

Research has shown that the church is more effective in information dissemination than other HIV and AIDS organizations. Therefore, it should play a central role in this regard, which entails equipping church people who are the caregivers. The church people who are the pastoral caregivers should have accurate HIV and AIDS information on definition and description, origin, infection, transmission and statistics in order to offer effective and informed care. *HIV and AIDS definition and description* : The difference between HIV and AIDS should be emphasised. HIV is the virus that would eventually lead to AIDS. AIDS is a condition in which the body is susceptible to any infection, since it can't defend itself. From HIV infection to AIDS it takes 10-15 years or even longer, depending on the attitude that the person adopts and the availability of antiretroviral drugs. Therefore, pastoral care should emphasize that being diagnosed HIV positive does not mean that you will die tomorrow. There is still life beyond infection.

Origin: There are some speculative theories regarding the origin of HIV, but there is scientific evidence that HIV1, which is more virulent and widely spread throughout the world, originated from a chimpanzee. A particular kind of chimpanzee is known to carry a virus quite similar in structure to HIV. HIV2 is less virulent and found in West Africa; it originated from the sooty manga by monkey.

Infection, transmission and statistics: HIV is passed on from an infected person to the next through unprotected sexual encounters (86%), through blood transfusion (<1%), and mother to child (13%). When the HIV enters the body, it attaches itself to the CD4 cells (i.e. special type of white blood cells) and multiplies. The body's immunity system declines since the defense system is being destroyed. When the CD4 cells are less than 200 the person is diagnosed as having AIDS. In this condition the body can't defend itself and is open to any invasion, hence the person may die from any disease. When the HIV enters the body, it progresses through various stages, but the process may be accelerated by poverty and a negative attitude to life. Africa, especially Sub-Saharan Africa, accounts for 70% of the HIV and AIDS cases in the world. The reason for the high figures are partly that the HIV has been around in Africa for a longer time (since it originated in Africa), the HIV clades found in Africa are more virulent, and some other factors like population movement, including the military; developed trade and transport routes; gender inequity and inequality; poverty and unequal distribution of wealth; lack of social cohesion in some areas; widespread sexual mixing and multiple partnerships ,including commercial sex; various cultural factors (e.g. low rates of male circumcision); high levels of untreated sexually transmitted infections and reproductive tract infections; and relatively low condom use..

The African perception of HIV and AIDS has a psychological function. The affected people are considered innocent but victims of angry supernatural forces. The community, therefore, views them as people deserving assistance. However, this interpretation has negative implications for people's sexual behavior.

The need for pastoral caregivers, who are congregation members, to be acquainted with HIV information is undoubtedly of strategic and paramount importance. People from different localities converge at church meetings for worship. HIV/AIDS information is no doubt crucial for the caring community.

Chapter 3: Interplay between Bible and HIV/AIDS

3.1 Has HIV/AIDS Written in the Bible?

This may seem like a very odd question, seeing as the virus and its resulting disease did not descend upon humanity until nearly two thousand years after the last books of the Bible were written. Closely related to this question is the one which asks what the church's response is to this disease and the plethora of issues surrounding it. Yet it is difficult to know how to respond before we know what if anything the Bible has to say about it.

Let's start with Jesus,(Always a good place to start.) What do his words and actions say about HIV? Well, at face value, nothing. But when we spend time digging deeper and looking closer, we realize that Jesus spoke and ministered to the most basic of human conditions that are found everywhere and throughout time: suffering, rejection, sinfulness, shame, and the desires for love, belonging, and redemption. All of these elements are familiar to anyone who has infected with HIV/AIDS.

When Jesus touched lepers, He provided more than physical healing. Lepers were the most ostracized group of people in Jesus' time. They were literally shunned by their societies and families, and sent to live by themselves or with other lepers. "Clean" members of society could not touch, eat with, or be knowingly in the presence of someone who had leprosy. Part of this was a misunderstanding of the disease that led people to think that it could be spread by touching a leper. However, there was also a belief that a person who had contracted leprosy had done something wrong to deserve it. He or she had sinned against God, and this was their punishment. In the sacrificial system of the Jewish temple, however, they were not able to offer a sacrifice for atonement because they were "unclean" and could not enter the temple.

When Jesus interacted with, touched, and healed people with leprosy he was making a statement. He was bringing justice. He was giving emotional and social healing as well as physical healing. He was restoring the humanity that years of shame and rejection had taken away. He was bringing the outsiders into the inner circle of relationship, chosen and blessings. The same is true for a number of other people groups with whom Jesus freely mingled. He ate with tax collectors, a despised group of people in the eyes of the first century's "religious right." He talked openly with women, even sinful women who were

known to be prostitutes. In John 8 we even see Jesus defending a woman who had been caught in the act of adultery, rescuing her from the punishment she deserved, and most importantly offering her free forgiveness. This is a Jesus who was fearless in breaking down the walls resurrected by judgment, shame, fear, stigma and sin.

Yet what can we learn from the life of Jesus? What does the Bible say about HIV and AIDs? It says that Jesus is not afraid of it. He's also not afraid of what causes it. Loud and clear, it says that Jesus' compassion, love, forgiveness and grace is extended especially for those who are suffering on the "outside," including those with HIV and AIDs. Knowing what we know about Jesus, I think it is safe to say that He would spend plenty of time with people who had been pushed to the outside by HIV/ AIDs. His whole mission was and is to bring outsiders in – into grace, into relationship, into forgiveness, and into the blessedness of being chosen by God.

Does Bible say that HIV or AIDS is God's punishment?

Is HIV, the human immunodeficiency virus, or AIDS, acquired immune deficiency syndrome, a punishment or judgment from God? The short answer, from many people of faith, is *"No! Absolutely not!"*

Two biblical convictions and one condition provide the context for developing a biblical vision of AIDS. The condition is leprosy; the first conviction holds that disease is not a punishment from God; the second conviction proclaims a faith that does justice. Underlying these convictions, of course, is the more foundational belief that all people are created in God's image and redeemed by Jesus and called to everlasting life.

Sickness As Punishment. Let's begin with the first conviction. Deeply embedded in some streams of Hebrew thought was the sense that good deeds led to blessing and evil deeds to suffering. If a person were experiencing sickness or other trials, then that person must have sinned in the past. This perspective is grounded in the Deuteronomy tradition, and is perfectly expressed by Job's "friends" (see the series of speeches in Job 3—31). The Book of Job, however, challenges this tradition; Job suffers despite his innocence. Job 31 is especially clear on this issue.

Jesus, too, challenges this belief. In the exquisite scene described in chapter nine of John's Gospel, Jesus heals a blind man. Then threats, excuses and faith take center stage. Even before the healing, Jesus declares that the man's blindness was not due to his or his parents' sin (John 9:2-5). Neither Job nor Jesus explains away the pain of suffering, but neither views sickness as a punishment from God.

Leprosy and the Purity Code. Next, let's turn to leprosy, one of those diseases that many interpreted as God's punishment. The Book of Leviticus devotes two chapters (13 and 14) to discussing this condition. The harsh rules describe an image familiar to the imaginations of many of us:

"The one who bears the sore of leprosy shall keep his garments rent and his head bare, and shall muffle his beard; he shall cry out, 'Unclean, unclean!' As long as the sore is on him he shall declare himself unclean, since he is in fact unclean. He shall dwell apart, making his abode outside the camp" (13:45-46).

It is helpful to note that the biblical term often translated as "leprosy" included many forms of skin disease, including psoriasis and ringworm. Scholars tell us that what we call leprosy today, Hansen's disease, may have entered Palestine around 300 B.C.E. and that many of those described as lepers undoubtedly had distasteful skin diseases but not Hansen's disease.

Whatever the actual disease, these people experienced alienation and rejection. Certainly, ancient peoples were afraid of contagion, but for the people of Israel leprosy became a ritual impurity more than a medical problem. They considered it divine punishment and feared that the community would also suffer if the leper were not forced "outside the camp."

Jesus not only rejects the judgment (John 9:3) but also crosses the boundaries of purity laws to touch the alienated. Mark's Gospel describes the scene this way: "A leper came to him [and kneeling down] begged him and said, 'If you wish, you can make me clean.' Moved with pity, he stretched out his hand, touched him, and said to him, 'I do will it. Be made clean.' The leprosy left him immediately, and he was made clean" (1:40-42).

With a simple but profound touch, Jesus breaks down barriers, challenges customs and laws that alienate, and embodies his convictions about the inclusive meaning of the reign of God. This dramatic touch is also described in the other two Synoptic Gospels, Matthew 8:1-4 and Luke 5:12-16.

This event reveals not only Jesus' care for an individual in need but also his concern about structures of society. Jesus steps across the boundaries separating the unclean and actually touches the leper. In doing so, Jesus enters into the leper's isolation and becomes unclean. Human care and compassion, not cultural values of honor and shame, direct Jesus' action. He calls into question the purity code, which alienates and oppresses people already in need. Indeed, this encounter with the leper is one example of how Jesus reaches out the marginal people in Jewish society, whether they be women, the possessed or lepers.

Faith That Does Justice. The second biblical conviction that provides the context for developing a response to persons with HIV/AIDS is the recognition that faith must be connected with politics, economics and all structures of society. Even though the ancient Hebrews had a profound sense of communal life, they had difficulty integrating faith into their daily lives—as we do today.

Again and again, the prophets challenged the people not to separate justice concerns from true religion. Isaiah powerfully expresses this conviction:

"Is this the manner of fasting I wish, of keeping a day of penance: that a man bows his head like a reed, and lie in sackcloth and ashes? Do you call this a fast, a day acceptable to the Lord? This, rather, is the fasting that I wish: releasing those bound unjustly, untying the thongs of the yoke; sharing your bread with the hungry, sheltering the oppressed and the homeless; clothing the naked when you see them, and not turning your back on your own" (Isaiah 58:5-7).

God does not create chaos or injustice. God brings order out of chaos, and demands justice where there is injustice. God does not cause tragedy, but God does respond to suffering with healing. God heals

sometimes through physical restoration, and other times with grace sufficient to grow in the midst of suffering, even in the face of death (I Corinthians 12:9). An example of God's healing grace is well-described by a woman with a friend who died from the complications of AIDS: "As a child, he had been abused and abandoned by his mother. But as an adult, in his last months, his mother came to live with him, nursing him around the clock. In their times together, old wounds were healed, forgiveness was shared, and faith grew. My friend received a healing gift of family and love he had never known."

Even when the injustice of tragedy invades our lives, God's passionate love can bring good in the form of healing and growth. We can find God's healing touch in our tears of sadness and our screams of anger. We can find God's healing touch in the words of love and comfort shared by others. More than anything, we can find God's healing touch through that inner peace that comes from God's presence and promises. We know that in everything God works for good with those who love God (Romans 8:28).

Finally, there are many victims of AIDS (hemophiliacs, infants and children, and those who received infected transfusions) who were infected through no specific actions of their own. I believe it is better to see AIDS, not as a specific divine judgment against one type of sin. Christians must reject the idea that HIV/AIDS is punishment for sin. People of faith, like Jesus Christ, must reach out with a healing touch. Rather than being understood as God's retribution. Suffering becomes an occasion for God's love to be demonstrated. *When Christians reach out and touch those with HIV or AIDS, they can transform suffering into a living example of God's love.*

Chapter 4 : The church understanding of HIV/AIDS people status

4.1 Definition and description of Church.

The word church comes from the Greek adjective, *to kuriakon,* used first of the house of the Lord, and then his people. But it is always used in the Bible to translate the Greek word *ekklesia* . However, it is important to underline that *ekklesia* does not refer to a building but to an assembly of people. *Ekklesia* (noun) is a word derived from the verb *ekkaleo* meaning to summon or to call out. The closest English equivalent of the word is convocation – a calling together, an assembly. It was the official term for the Athenian democracy. And it is in this secular sense that it used in Acts 19:32,39,41 . However, the New Testament use of *ekklesia* is controlled by its employment in the Septuagint (LXX) to translate the Hebrew *qahal*, which has the same meaning of a convened assembly (Grudem 1994:853). In the strongest sense the *qahal*is the assembly of Israel convened by God (Deut. 23:2-9; 1 Chronicles 28:8; Numbers 16:3,20:4, etc). Thus in the New Testament *ekkle*sia used of a public assemblage summoned by a herald and in the Old Testament (LXX) refers to the assembly of the Israelites, especially gathered before the Lord. Therefore, both in the New Testament and Old Testament (LXX) *ekklesia* denotes an assembly of people called together, which could be taken as the church.

The church is comprised of two aspects:

1) The universal church consists of all those who have a personal relationship with Jesus Christ. “For we were all baptized by one Spirit into one body—whether Jews or Greeks, slave or free—and we were all given the one Spirit to drink” (1 Corinthians 12:13). This verse says that anyone who believes is part of the body of Christ and has received the Spirit of Christ as evidence. The universal church of God is all those who have received salvation through faith in Jesus Christ.

2) The local church is described in Galatians 1:1-2: “Paul, an apostle … and all the brothers with me, to the churches in Galatia.” Here we see that in the province of Galatia there were many churches—what we call local churches. A Baptist church, Lutheran church, Catholic church, etc., is not the church, as in the universal church—but rather is a local church, a local body of believers. The universal church is comprised of those who belong to Christ and who have trusted Him for salvation. These members of the universal church should seek fellowship and edification in a local church.

4.2 Mission of the church.

1. To Preach the gospel

This is the primary mission of the church because the church is God's agency preaching the gospel is the primary mission of the church because the church is God's agency to evangelize the world. Jesus compared the church to a householder who went out into the marketplace to hire laborers into his vineyard, Matthew 20:1-16. Jesus also compared the nature of the kingdom of heaven to a sower who went forth to sow. The seed the sower was sowing was the word of God, Matthew 13:3-23. In early days, the church was God's agency to send preachers out to preach the word and do the work of God. The Bible says of the church at Antioch, "And when they had fasted and prayed and laid their hands on them, they sent them away" (Acts 13:1-3).

2. To provide Spiritual atmosphere

It is the mission of the church to provide the kind of place where spiritual life can flourish. The meetings of the church should be the kind of meetings where the spiritual man, the inner man, can be renewed. The services should be orderly and worshipful.

It is not necessary to have the most eloquent speaker, or the most entertaining singing to build up the spiritual man. What does matter is to meet with a desire to worship and serve God in spirit and in truth, as Jesus instructed in John 4:23,24, and to show genuine love and concern for each other. Jesus said: "By this shall all men know that ye are my disciples, if ye have love one to another" (John 13:35). Therefore, it should be the duty and mission of every member of the church to make it a place that is warm, friendly, receptive, and encouraging, and to show love for this world, even as Jesus loved the world and gave his life that he might redeem it from sin.

3. To reproduce the character of Jesus

Another mission of the church is to provide in its members the kind of person that Jesus wants to see. The objective of every church is to produce the likeness of Christ in the lives of its members. The apostle Paul commanded: "Let this mind be in you, which was also in Christ Jesus" (Philippians 2:5).

That is the purpose of all our worship and work - to reproduce in our own lives the character of Jesus Christ

4. To respond to human need by loving service

The Bible is replete with calls to Believers to address the needs of those who are suffering, illnesses, poverty, afflictions, homeless and in distress. Jesus Christ reached out and healed those who came to him, including people who were despised and rejected because of their illnesses and afflictions. His identification with suffering people was made clear when he said that “whatsoever you do to the least of these, you also do to me” (Matthew 25:40, paraphrased). His commandment to “do to others as you would have them do to you” (Matthew 7:12) is a basis for the church for full involvement and compassionate response.

2.3 Church response to HIV/AIDS infected people

Many local churches insist that extramarital sex is “sinful;” some even go so far to say that AIDS is God’s punishment for sexual transgressors. Such negative attitudes often lead to denial of AIDS in public church settings, creating a setting in which church members living with AIDS are reluctant to disclose their HIV status – leaving people to suffer the disease’s terrible emotional and physical ravages completely unsupported by what was likely their most significant social network

However, this is not always the case. There is evidence that, in some cases, the church has played a key role in supporting members living with or affected by HIV/AIDS. This role includes visiting the sick, praying for them, and offering them varying forms of practical help. There are even a few cases when churches have spoken openly against the stigmatization of victims of AIDS, and emphasized the need for the sick to be loved and supported, rather than judged and rejected.

The church has a significant role to play in the global HIV/AIDS pandemic. However, we must accept that this role will require a long-term commitment. There are no universal or quick solutions. The Church must engage and stay at the center of prevention and care for the foreseeable future. It can do this in four ways:

1) Grace: Grace and Peace from God our Father and the Lord Jesus Christ! Grace is a central theme in addressing HIV and AIDS biblically. Having understood the HIV and AIDS situation, the church’s first reaction to HIV and AIDS should be of compassion and acceptance, not condemnation. Stigma and judgment are symptoms of a bigger problem – a deficiency of grace in the church’s communal life. A lack of awareness of both our sinfulness and the immensity of God’s saving grace contributes to this

problem. The journey from judgment to grace needs to be made deliberately, one step at a time. Christ's people must extend the grace they have received to the infected and to one another.

2) **Practical Theology/Pastoral Circle:** Practical Theology means presenting the Gospel in ways that are relevant to the life of the people with whom the church is in relationship. This is crucial. The Pastoral Circle is a tool used in this regard and involves identifying and analyzing practical problems / experiences encountered by the church, reflecting biblically upon them, and then responding wisely, holistically, and effectively. Practical theology should be contextual, communal, gender sensitive, and open to informal expressions (such as prayer, music, drama, and dancing) in addition to formal ones.

3) **Christology/God's Character:** Our attitude towards the sick and marginalized in society (such as those with HIV and AIDS) should be the same as Christ's, who was full of grace, compassion, mercy, and love. Jesus was most critical of the hypocrites and the judgmental but 'a friend to tax collectors and sinners' (Mt. 11:19). The parable of the Good Samaritan (Luke 10) illustrates His character. Teaching and endeavors in HIV and AIDS ministries must be grounded in a thoroughly biblical theology.

4) **Family priorities:** Biblical principles of marriage and parenting must be taught in the church and modeled in the lives of believers. Our God-given priority is to our spouse and children. Children need the love, teaching, and mentoring of their parents in order to be able to avoid many of the traps that lead to a life-style that is prone to HIV and AIDS.

5) **Behavior change:** Changing sinful attitudes and behaviors necessitates courageous biblical teaching about taboo issues, such as sex, combined with godly role models. With behavior issues it is helpful to ask, "Why are you doing this?" or "What does it mean?" People need to understand what is at the root of their behavior and take ownership in changing it. We must all remember that Christ through the work of the Holy Spirit in the believer's life is the one who performs the internal transformation necessary to bring about behavior change. Authentic transformation results in repentance, forgiveness and reconciliation.

In conclusion, HIV and AIDS should be seen as an opportunity rather than a burden for the local church. God often uses adversity to draw us to Himself. The church should be a place of refuge where people want to come in their time of need. It provides a unique opportunity for the church to display Christ's love and to pursue increasing conformity to the image of Christ. "If the church of Jesus Christ rises to the challenge of HIV/AIDS it will be the greatest apologetic the world has ever seen!" (Theologian Ravi Zacharias).

The local church, and in particular its leadership, need to receive training on HIV and AIDS and need to interact with those infected. Practical HIV and AIDS training should be integrated into theological education at Bible colleges and universities. The church has a biblical mandate to live out care and concern for widows, orphans and vulnerable children. The response of the church has been too often judgmental, anemic, or cautious, but it must change and become gracious, wholehearted and holistic.

The biggest issue which local churches have, it is lack of training and equipping on Pastoral counseling to HIV/AIDS infected people especially those who are born with it. Which will be discuss in the next chapter.

Chapter 5: Pastoral counseling to people who are born with HIV/AIDS

5.1 *Introduction to Pastoral counseling*

Pastoral counseling accepts the Bible as the final authority. Christians are not tossed back and forth and do not rely on their conscience, but they have the Word of God that is valid and defines men's*telos* and purpose. Pastoral counseling does not only depend on the human will to be responsible, but they have the Holy Spirit that assists them. Although human beings, by nature, are selfish and ignore or hate God, through faith they receive the Holy Spirit, who gives them victory in overpowering their sinful nature. It deals effectively with the counselee's past. Because people's past guilt is forgiven (1 John 1:9), they can look to the future (Phip 3:13-14).It is based on God's love. God loves us and his love flows through us as we care for others (Rom 12:9-21). A Christian counselor feels a spiritual relationship to others and helps them to grow in Christ as they solve their problems. Pastoral counseling deals with the whole person. It recognizes that the physical, psychological, and spiritual aspects of humans are intricately related. Different from the broad and general outline of Meier*et al.*, Clinebell (1984:67-70) identifies three key distinctive characteristics of pastoral counseling. Firstly, the heart of pastoral counseling is its uniqueness, its theological and pastoral heritage, orientation, resources and awareness – the awareness of the Spirit of God's omnipresence as the core of reality that influences everything that pastors do, including counseling. The realization of this spiritual dimension is central to pastoral counseling. Pastors' unique training that orients them to both theology and psychology allows them to handle humans holistically. The theological knowledge of issues, such as life after death, helps to impart meaning to people.

Second is the pastoral counselor's working premise. Spiritual growth is an essential objective in all caring and counseling, which is uniquely pastoral. The counselor's goal is to foster spiritual wholeness as the core of the whole person. And in all that the counselor does, spiritual growth is central. The third unique feature is that pastoral counselors are expected and are (hopefully) trained to use the resources of their religious tradition as an integral part of their counseling. In addition to prayer and Scripture, most of the church tradition rooted in Scripture can bring healing, if used well. The setting and context of pastoral counseling, which is ecclesial, places the counselor in a unique position to assist people. The daily network of relationships, and the accurate knowledge of church members' lives, allows the counselor to intervene at any time when he/she notices a problem. This certainly places pastoral counseling a notch above secular counseling, which only operates on the basis of what the client says during the counseling session. Uniqueness of pastoral counseling by focusing on its goal. He says that when people experience problems, they place "top priority not on becoming Christ-like in the middle of problems but on finding happiness". However, it should be noted that the goal should not be happiness (as psychology may claim), but to respond biblically by putting the Lord first (spiritual maturity), and to seek to behave as He would want us to. As we devote all our energies to the task of becoming what Christ wants us to be, He fills us with unspeakable surpassing joy and peace, beyond what the world offers. Therefore, the goal of

pastoral counseling is to encourage one to become more Christ-like (maturity in faith), and the by-products will be eventual peace, healing and happiness. The reason why people seek to have obstacles (problems) removed from their way should be to promote worshipful life, i.e. so that they will be able to worship God more fully and serve Him more effectively. Summarized the goal of Christian counseling simply as "to free people to better worship and serve God by helping them become more like the Lord. In a word, the goal is maturity".

Maturity is both spiritual and psychological. For one to become psychologically whole and spiritually mature, one must understand clearly that one's acceptability to God is not based on one's behavior, but rather on Jesus Christ's behavior (Tit 3:5). Although people remain sinful, Jesus' perfect life justifies them. Justification brings self-acceptance, as people regard themselves with the understanding that they do not need to do anything to be acceptable, because Christ did everything for them. As a result, all the attention is paid to the God of Scripture as the only Person to be pleased. "The foundation of the entire Christian life then is a proper understanding of justification" .Christians' final destination is glorification, which is also entirely God's work. But, between justification and glorification (eschatology - now and not yet) is the life we are living (the life of obedience empowered by the Holy Spirit). During the present times people stray from the path of righteousness and do not follow biblical patterns. Therefore, Christian counseling is concerned whether the person is responding biblically in whatever situation he/she experiences. Regardless of the situation or background, God's faithfulness assures us that the client/counselee has all the resources that he/she needs for learning to behave biblically in the particular situation. "A counselor must help the client to move OVER to the pathway of obedience". "Moving over" entails removing roadblocks in the journey, such as "I can't" or "I won't". Helping a client to "move over" is part of the goal. However, a Christian should go beyond behavioral change. Attitude must change, desires should slowly conform more to God's design, and there must be a new style of living . The change must not be only external obedience, but also an inward newness, a renewed way of thinking and perceiving, a changed set of goals, and a transformed personality. I call this second, broader objective the up goal. People need to move not only OVER but also UP. Psychology, however, disregards this phenomenon of moving OVER to biblical conformity and rising UP toward an attitude of Christ-like submission to God's will. But pastoral counseling focuses on it, which underlines its unique contribution. In HIV/AIDS counseling, therefore, where death is pending and the person experiences guilt.

Despair, one should emphasize God's acceptance and unconditional love. Thus the people involved in HIV/AIDS counseling should be sensitive to spiritual needs that should be addressed by means of communicating the Gospel. If HIV/AIDS-infected young people view themselves as acceptable before God, and entrust themselves to God's hands, healing may occur. These people would have "moved over" and now think biblically. The process of "moving up" would have started. Further clarifies the nature of pastoral counseling in four ways:

1) The Word and the Spirit are most factors in pastoral counseling, thereby establishing the dialogue.

2) Pastoral counseling is essentially a hermeneutical process of interpreting and understanding the Christian faith within human contexts;

3) The covenantal character of the communication between God and humankind implies that parishioners are being approached by the pastor in terms of grace and love (*agape*);

5) In pastoral counseling, a pastoral diagnosis deals with a very specific issue: the association between God images, faith development and growth (maturity)

6) The content (what) of pastoral counseling is determined by the notion of salvation and the dynamic influence of God's promises in Scripture.

7) The source of pastoral counseling is the Spirit, who communicates the faithfulness of God.

8) The counselee (who) of pastoral counseling: parishioners as well as all people in need and created in the image of God.

9) The reason and motivation (why) for pastoral counseling: the compassion of God, the Father, the reconciliation of Jesus Christ, the Mediator and consolation of the Holy Spirit provide the motive for the pastor's involvement in counseling.

10) The attitude (how) of pastoral counseling: *agape* love, as exercised through priestly compassion and real charity.

11) The 'objective' of pastoral counseling: mature faith, a vital hope and the disclosure of significance and meaning.

12) The environment and context (where) of pastoral counseling: the *koinonia* within the fellowship of believers *(communio sanctorum)* and the social and public context. Pastoral counseling should therefore manifest and represent in a very symbolic way the mutual care of believers as well as the compassion of God.

God's love flows through the believers as they care for one another (mutual care). A Christian counselor feels a spiritual relationship to others and helps them to grow in Christ as they solve their problems (Meier 1991). Pastoral counseling therefore implies that believers who experience God's love and grace share it with others. In such a context of a "love bond", acceptance and oneness are fostered, which encourages mutual care. Those that are born with HIV/AIDS positive are accepted and become part of the Christian family. This ecclesial context, places pastoral caregivers and counselors in a unique position to assist those affected. The daily network of relationships and the accurate knowledge of church members' lives allow one to be there to "intervene" whenever there is need. Furthermore, the centrality of grace in pastoral counseling encourages acceptance of HIV/AIDS-infected people. The longing for every individual soul is to be viewed in terms of grace. God's grace through his unconditional love should flow to other people. Other members should reassure those who are born with HIV/AIDS infected who fear stigmatization and discrimination grace and acceptance. *Koinonia* acceptance communicates practically a God-image of God who identifies and cares which encourages trust and faith (faith and spiritual development) to the affected people. But how does pastoral counseling proceed? The notion of salvation and the dynamic influence of God's faithfulness determine the content (the what) of pastoral counseling. A counselor enters into an encounter with total faith in God and with the

aim of communicating Him (i.e. by means of the Gospel) to the counselee so that there will be a convergence of his/her need with the voice of the Gospel.

HIV/AIDS counseling should, in their support care and counseling, have the desire to allow these young people to experience salvation, because works of compassion are not an end but a means, and a voice of God's kingdom where the fullness of healing and peace is found. They say that AIDS ministry (care and counseling) is "not primarily evangelistic ministry". While the kerygmatic approach to counseling is discouraged, the centrality of Scripture and hope of pneumatology in bringing transformation cannot be over-emphasized. Although Sunderland explains that this means that there should not be pressure to convert the person, a Christian counselor's goal always is spiritual maturity (either implicitly or explicitly) and the first step to maturity is union with Christ (who is the source of hope). At all times, pastoral counseling should attempt to communicate the Gospel, which is the healing instrument, since it mediates God's promises. And it should be done within the notion of fellowship *(koinonia).*

The pastoral counselor, however, should be aware that, although he/she has a responsibility to communicate the message as clearly as possible, it is the Holy Spirit who communicates God's faithfulness and brings change and healing to people. In addition the pastoral counselor should view all people as created in the image of God; hence they are objects of our unconditional love. This understanding changes people's orientation and allows them to offer the best care and counseling possible. The motivation would be God's compassion and the reconciliation of Christ, which is practiced lovingly. And, in so doing, HIV/AIDS-infected young people who may be discriminated and stigmatized will find hope in God as they embrace his love and grace and exploration of deeper and complicated issues, which is the role of Christian professional counselors. Crabb's model of congregational counseling seems very practical and applicable in HIV/AIDS counseling.

Thus far the uniqueness of pastoral counseling and its implications for *koinonia* (systems) approach to counseling has been discussed. In the discussion and the many other previous sections, the words "healing" or "therapy" have been mentioned. Therefore you may ask: how is pastoral healing achieved? Is healing possible for HIV/AIDS-infected people? What is the healing function of *koinonia* for HIV/AIDS-infected people?

5.2 Healing and hope in pastoral counseling (therapy)

Pastoral care and counseling are conceived as a healing art. Healing permeated Jesus' ministry. De Gruchy, cited by Louw (1998:440-441) argues that healing cannot be separated from the notion of salvation. Jesus and the early Christian community's healing ministry were integral for the proclamation of the kingdom. Healing in the Bible reflects a holistic understanding of humanity and reality. The concept of *shalom* is about not only the human psychic and physical, but also the social and political, order. Therefore, De Gruchy connects salvation and healing as that which enables us to be fully human in relation to our society, our environment and us. Both are indicators of healing and humanization.

In medicine therapy is different from what it is in the helping professions. Medical eradicates pain through medication, while the helping professions are concerned with the treatment or help that is focused on healing and recovery through communication. Psychotherapy, as Tydeman cited by Louw

(1998:442) states, is intended to help the patient to gain insight so that honesty about oneself (self-knowledge) could create an inner knowledge, which sets one free. And, in doing this, the counsellor needs genuineness, non-possessive warmth and accurate empathy. However, there is a clear difference between therapy in psychology and theology. Louw (1998:443) describes the difference thus: Psychotherapy concerns a person's personality functions and problems on an intra-psychic, inter-personal and contextual level. Pastoral therapy is primarily concerned with problems on a spiritual level: it focuses on people's functions of faith and their relationship with God. In so far as psychic, relational and contextual problems are at issue in pastoral care, they are connected to belief and the quest for meaning in life. Furthermore, growth and development in theology is not related to inner potential, but to the charismatic potential in the pneumatic person.

He strongly warns that pastoral therapy does not merely lie in the pastor's Christian faith, a person's biblical view, or the notion of the reality of sin. Neither does it lie in a careless mix/dilution of theology with psychology. Christian therapy, which he terms, "promissiotherapy", seeks to foster maturity of the whole person. Its objective is spiritual maturity, faith development and growth. "Promissiotherapy is offered by the *koinonia* and is based on theology: God's faithfulness to his promises and the healing dimension of salvation" (Louw 1998:444). Schiller, cited in Louw (1998:444), explains this phenomenon:

Salvation therapy includes liberation towards eternal communion with the Triune God, as well as a transformed attitude regarding the meaning of human life; a disposition of love for the fellow human being; courage and joy in life in trusting God; and hope for the future which endures throughout the process of dying and death. The therapeutic issue resides in the Christian's life once there is a living and committed relationship with Jesus Christ.

The context of pastoral therapy is the community of faith. And, it has the Gospel's comforting and caring dimension. Pastoral therapy is intensely concerned with the paracletic dimension of salvation. Therefore, the characteristics of Christian/pastoral therapy, i.e. promissiotherapy, are:

- It is concerned with the paracletic dimension of salvation;

- Its context is *koinonia,* the community of faith (fellow-believers);

- The Gospel is central – God's faithfulness to his promises;

- Its goal is maturity, faith development and growth. Louw (1998:448-449) summarises the therapeutic effect of pastoral counselling in five solid statements:

* Firstly, Pastoral therapy, as an exponent of grace, is essentially linked to God's faithfulness and his promises. This linkage to God's faithful promises and salvation means that pastoral therapy can be typified as promissiotherapy in terms of its therapeutic effect. In biblical counseling, the therapeutic effect of promissiotherapy is that God's faithfulness to his promises encourages the growth of faith in the human heart, and that this faith offers certainty and security. Furthermore, faith brings gratitude to the suffering. The communication of God's promises in a concrete way to bring therapeutic effect makes promissiotherapy distinct from psychotherapy. It has a different goal (i.e. faith maturity), effect

(reconciliation) and uses different media to generate change (i.e. Scripture, prayer, sacraments). Promissiotherapy, as salvation therapy, focuses on forgiveness and justification by grace as important therapeutic components, which is crucial for the guilt and despair that the HIV/AIDS person who is born with it, may be experiencing and the forgiveness he/she requires.

* Secondly, Promissiotherapy also engages with the issue of anticipation in our human existence, thereby creating hope in the human heart; promissiotherapy is an exponent of the eschatological stance in theology. God's promises are not only for the future, but also in the immediate context (already and not yet). Our being in Christ influences our actions as we look into the future. Thus from the disclosure of the HIV/AIDS young person's status, one should not focus on the infection, but view him/herself as active and contributing to the society in which he he/she belongs. The person should feel life-ness, positive and hopeful, and the *koinonia* should make such people feel so through acceptance.

* Thirdly, While the immediate effect of promissiotherapy is faith, the transformation of human existence to that of a new being - the long-term effect of promission therapy

It is anticipation and a positive stance in life (God's yes to our being functions). Transformation of faith generates hope and connects life to the fullness of salvation. The eschatological tension between the already and the not yet creates a foundation of expectation which fosters meaning in life.

* Fourthly, Promissiotherapy in pastoral counseling creates hope and discloses a future dimension for the believer. Hope discloses a horizon of meaning, wherein the believer may enjoy daily victorious life because of the indwelling power of the resurrection. Christian hope is basically resurrection hope. At a therapeutic level, this hope affects a positive process of anticipation.

* Fifthly, when people's future orientation is obstructed, their horizon is also blocked. A blockage of future orientation and loss of meaning in life is a fundamental factor in all dysfunctional human behaviour.

In Christianity, meaning is not structured around values in life, but around the person of the resurrected Christ. The Christian understanding of meaning in life is the confession of faith: Jesus Christ is the Lord. The confession, "I believe in the resurrection of the flesh", means life is reconciled through the cross, and victorious life through the resurrection. Life, apart from the dimension of eternal life, loses its prime focus and is surrendered to the odor of death. Salvation therapy, hope therapy and promissiotherapy all refer to pastoral therapy, i.e. God's faithfulness, his promises, and the Gospel's offer of redemption. Perspective (salvation), ontic condition (faith) and orientation to the future (hope) are three similar issues, which clarify the distinctiveness of pastoral therapy from various other aspects. Salvation, faith and hope are responsible for giving meaning to life and energizing the person to live meaningfully, purposefully and responsibly, even with HIV/AIDS infection. During the encounter the Christian counselor is responsible for enfleshing sacrificial love, which is his/her motivation, and the Holy Spirit applies the healing (trialogue). The hope cultivated in the person becomes the spring of life as one lives doxologically. Pastoral therapy, therefore, effects HIV/AIDS healing. Its healing effect is an invaluable fact. And as has been argued earlier, the congregation *(koinonia)* remains the nucleus of this healing ministry. However, caring is not an end in itself. It aims to communicate the salvific grace of God in Jesus

Christ, which is the initial stage of faith maturity and spiritual development. While the caregiver should guard against a kerygmatic approach, the Gospel should be central, since it is the only authentic voice of God's love and grace. Salvation dispels all fears, guilt, anxiety and despair from HIV/AIDS-infected people as they recognize their new relationship with the Author of the universe who is in control. Faith makes them stand up and appropriate God's promises and security in Christ

5.3 Pastoral counseling diagnosis.

Pastoral counseling and diagnosis are two sides of the same coin. They cannot be separated from each other. A counselor needs to determine what the person is experiencing in order provide the appropriate support and counseling. The disclosure of the HIV – positive status to an individual may sound like a death sentence. It triggers unprecedented anxiety, fear and despair. Diagnosis allows a counselor to determine the magnitude of one's crises and disorientation due to the disclosure of the infection. And in HIV/AIDS pastoral counseling the aim is to remove the roadblocks that obstruct one from developing in faith and spirituality due to the HIV status. However, we should be hasten to add that regarding HIV/AIDS counseling the focus should not only be on the infected person, but also on the family members (significant others). Coping with HIV/AIDS to a great extent depends on the quality of support (relationships – family, friends including church members if one is a Christian).

Pastoral diagnoses seek to understand and analyze the quality of a person's faith and spirituality. Charles Taylor (1991:61-80) calls this process "theological assessment." The events taking place in a person's life are understood from a Christian faith perspective, i.e. eschatology. An assessment of faith is done in terms of God-images and life's ultimate meaning. However, this does not mean that emotions and experiences are ignored.

A diagnosis does not focus on a procedure of classification through which behavior is categorized and typologies in advance. Diagnosis is simply the interpretation of the person's total existence. It focuses on clarification, establishing connections, organizing data and interpreting behavior in terms of the quest for meaning. Focus on the organizing, summarizing and interpretation of data enables a pastoral diagnosis to establish links between faith and life; between God-image and self-understanding; between Scriptural truth and existential context.

In HIV/AIDS counseling diagnosis, the aim is to understand how people respond to their HIV positive status like what the experiences are that make these people react in that particular way. Thus the counselor seeks to interpret the person's understanding of God amid HIV/AIDS infection.

***Diagnostic models and pastoral metaphors**:*

Stage 1 : Identify problem fillings

Stage 2: Identify problem Behavior

Stage 3: Identify the problem of thinking

Stage 4: Clarify Biblical thinking

Stage 5: Secure Commitment

Stage 6: Plan and carry out biblical behavior

Stage 7: Identify Spirit- controlled feelings

The first stage is to "identify problem feelings". Feelings are a necessary initial focus in order to help the counselor trace the roots of the problem.

Secondly, "identify goal- oriented (problem) behavior". After the negative feelings have been identified in stage one, the wrong goals that the person has been pursuing usually are obvious.

Thirdly, "identify problem thinking". Once the wrong thinking has been identified, convince the client that his/her thinking is wrong and present persuasively the biblical route to meet personal needs, as suggested.

Fourthly, "change the assumption or perhaps clarify Biblical thinking". Commitment to act on the basis of the newly learned assumption then follows, which is critical, because a behavioral change will not flow automatically from changed thinking.

Fifthly, "secure commitment". In the sixth place, "plan and carry out Biblical behavior". Lastly, "identify Spirit-controlled feelings". Capps (1984:66-69), in *Pastoral care and hermeneutics*, states six diagnostic types in pastoral counseling, which he calls "theological diagnosis":

1. Theological diagnosis as identifying underlying personal motivations;

2. Theological diagnosis as identifying the range of potential causes;

3. Theological diagnosis as exposing inadequate formulations of the problem;

4. Theological diagnosis as discovering untapped personal and spiritual resources;

5. Theological diagnosis as bringing clarity to the problem;

6. Theological diagnosis that assesses a problem in terms of the deepest intentions of shared human experience. These six diagnostic approaches are placed in three models of theological diagnosis, i.e. contextual, experiential and revisionist models:

- The contextual model includes 2 and 4;

- The experiential model includes 3 and 6;

- The revisionist model includes 1 and 5.

Diagnostic model Pastoral models

Diagnostic model	Pastoral models
Contextual model Approach to problem - Causes of problem - Available resources Anticipated disclosure: Resourceful God justifying hope	Shepherd Praxis: - Views problem in context - Identifies relevant resources Self- understanding: Ministry of competent guidance
Experiential model Approach to problem - How problem is experienced - How problem may be shared Anticipated disclosure: God, full of grace, supports risk and loving God shares pain	Wounded healer Praxis: - Shared the pain of others - Encourages deeper experience of self and others Self- understanding Ministry of personal vulnerability
Revisionist model Approach to problem: - Sees problem in a new way - See ourselves in a new way Anticipated God evoking the truth	Wise fool Praxis: - Challenges distortions - Encourages new-perspectives Self- understanding: Ministry of basic truthfulness

Anticipated disclosure:

Self-understanding: Perceptive God evoking the truth. Ministry of basic truthfulness the pastoral models of shepherd, wounded healer and wise fool depict the role or action that the pastoral counselor should perform; his/her functions should be eclectic. The shepherd as the guide (Ps 23), and protector (John 10), is aware of the range of possible causes of the sheep's discomfort and the resources available for the sheep to cope with life's perils. The wounded healer and the experiential type is rooted in Christ's suffering. He suffered in humanity. The counselor, as part of humanity, participates in our suffering by sharing experiences in communication. Healing does not come by taking away pain, but by living pain fully. The deeper we go into our painful experiences, the more we experience our common humanity with others and acquire a more profound awareness of God's love. The wounded healer has the same concern as the shepherd, but does not address pain by mobilizing available resources. He/she encourages us to live in pain, while the shepherd holds out hope for us.

The wise fool and the revisionist is characterized by simplicity, loyalty and prophecy. According to Paul in 1 Corinthians 3:18, the wise fool is not wise but a fool by the world's standards. He/she is simple in refusing to embrace empty professionalism; loyal in regard to persistent loyalty to others with disregard of self; and prophecy in challenging the accepted norms and conventions in society. The wise fool helps people to see themselves in a clearer light as he/she prophesies by challenging what our institutions are doing; is simple as he/she challenges us to conduct our lives with less self-serving distortion; is loyal as he/she challenges us to be more truthful in our interpersonal relationships. Furthermore, the revisionist

model helps us to see life in a new way and revise our ways as the wise fool confronts and challenges us. Louw (1998:39-54) concurs with Capps's three pastoral metaphor models of shepherd, servant and wise fool. But he adds a fourth metaphor, *paraklesis* . The shepherd metaphor views care as a mode of pastoral ministry. The servant metaphor views the pastor's (wounded healer) therapeutic service as pastoral identification. And by the wise fool metaphor, the pastor stands in a paradoxal relationship to the norms of discernment and understanding. The *paraklesis* metaphor refers to comforting, guidance, direction and advocacy or voicing on behalf of the voiceless as a pastoral mediation of salvation

The *paraklesis* applies the Gospel to the HIV/AIDS young person when in despair, thereby bringing comfort and peace. Apart from crucially applying the Gospel to the sufferer, the *paraklesis* advocates for the poor whose rights are not upheld. In addition, Clinebell (1984:31) proposes the model of holistic growth diagnosis. He views the role of care and counseling as to empower growth toward wholeness in all of the six interdependent aspects of a person's life. The six dimensions are enlivening one's mind, revitalizing one's body, renewing and enriching one's intimate relationships, deepening one's relationship with nature and the biosphere, growth in relation to the significant institutions in one's life, and deepening and vitalising one's relationship with God. Diagnosis seeks to determine where there is a problem in relationships in order to foster growth and develop spirituality, which is the centre of the model.

The other model is the life story (narrative) model. Its premise is that past religious experiences influence the way in which a person deals with problems. McKeever'smodel, cited by Louw (1998:309), is an example of this model. The pastor must hear the person's life story since the problem is embedded within a broader field of historical events. Fowler also proposed the developmental stage model that defines faith in terms of its consequences on human behavior.

The above models, in one way or another, reveal that diagnosis in pastoral counseling should consider the criteria that Louw (1998:317) lists below. These criteria can be linked very well to AIDS counseling, which is our focus. However, the question is: why is diagnosis necessary for HIV/AIDS pastoral counseling? HIV/AIDS-infected people have to deal with physical crisis, emotional crisis, relational and communicative crisis, identity. crisis, existential crisis and spiritual crisis that should be determined (Porte 2003:6-8).

Firstly, problem thinking and problem behavior . Problem thinking strongly influences behaviour and people's self-esteem. In our case, from the day that one is diagnosed HIV positive, the person may be depressed and stop eating, and he/she may view him-/herself as wasting away and everybody laughing at him/her. As a result, this person's condition deteriorates rapidly. Such ways of thinking should be discouraged and the person should think positively. And thinking positively in Christian counseling is thinking in a biblical way, which results from knowing that a person's self-esteem depends on a relationship with Christ (Crabb 1979:138).

Secondly, historical context and life story. Determining the influence of past events within the context of all facts can enable one to understand more about a person's history or life story. Family history, values

gained and internalized during the person's upbringing and patterns of interaction within family ties are important pieces of information for understanding faith patterns.

Physical crisis

Results from physical losses such as the strength or energy to prepare one's own food, personal hygiene, etc., conflict with your body as it fails to do what it used to do, and general loss of weight. HIV/AIDS brings unavoidable torment and distress, which triggers.

Emotional crisis.

The person has questions about the duration of the disease, as well as about career and family. The person may also interpret everything in terms of the HIV or focus excessively on health. There are also emotions of denial, anger, fear, guilt loneliness, depression and acceptance and resignation.

Relational and communicative crisis

It is a result of the negative effect on relationships due to stigma. The person has a fear of being rejected and exposed. The family and social network within which the person lives, is confronted by his/her intense emotional behavior, which may damage relationships.

Identity crisis

As he/she struggles with personal worth, family acceptance, or redundancy, as he can't do anything besides lie in bed.

Existential crisis

Develops as a result of the life-threatening nature of HIV/AIDS. The person doubts the meaningfulness of his/her existence. Dreams, hopes and opportunities for children vanish. The person struggles with meaning.

Spiritually crisis

The person feels as though God has turned against him or her. The person may even think that God is punishing him/her. To tell his/her story, especially if the person does not remember the circumstances of the infection, pressurizes the person. Besides, where one was innocently infected, this brings unnecessarily painful memories. Therefore, the history of HIV/AIDS infection should be avoided. *Thirdly, ego- strength and purposefulness*. This refers to the person's ability to deal with impulses, feelings, needs and significant decision-making. Value systems, goals and their ethical context play a major role in developing discernment and responsible decision-making. Some people break down from the moment they are told that they are HIV positive until death, while others cope easily and positively. Still others commit suicide, or decide to infect many others: "I will not die alone!" Therefore, guidance and confrontation should be the way for people who may be harmful to others. This again proves the value of Christian counseling, since the person will be encouraged to value other humans and not contemplate revenge.

Fourth, social analysis. Community structures and the nature and character of existing relations should be analyzed for a better understanding of faith behavior. This is common, where people live in a network of relationships. If the relationship is not healthy, the person certainly breaks down. *Fifth, coping skills and temporal events*. There is a link between the past, present and future. The person's ability to anticipate future-oriented behavior and goals should be studied to determine to what extent faith has a regressive or progressive function. The HIV/AIDS person in Christ has eschatological hope that latches this person onto high hopes and positive living. *Sixth, interplay between motive, need and expectation – vocation*. The person's level of motivation, as well as basic needs, role expectations and tasks should be analyzed. The HIV/AIDS person undergoing Christian counseling should have his/her needs in line with Scripture, as Crabb points out.

Seventh, the ethical dimension. This refers to the role that norms play within the level of a person's moral awareness and conscience. In a pastoral diagnosis a mature faith also examines the ethical dimension of the growth of faith. Even in HIV infection, the ethical person seeks to preserve the lives and safety of others, which should be the product of the HIV/AIDS counseling approaches. *Focus areas for faith assessment:* Effective pastoral counseling requires a focus. It is important to know the root cause of any problem. Louw designed a chart that aims at the following important pastoral categories: a mature faith - an analysis of faith; commitment and practice - religious analysis; God images - theological analysis of God concepts; and experiences of God. An analysis of faith would seek the suffering person's responses in his/her situation regarding the following: the intensity and degree of suffering; negativity and feelings of guilt; the quest for meaning; maturity in faith; belief and content of faith, assessing faith types; a test of virtue. Questions regarding the situation are asked and responses are analyzed. Religious analysis seeks to determine the character of parishioners' commitment, i.e. practices and rituals. Religion can be dysfunctional, e.g. artificial religion (religion as superstition); conventional religion (religion as tradition); legalistic religion (religion as duty); neurotic religion (religion as an obsessive factor for perfection); and pathological religion (religion as an alienating factor). Religion can also be constructive, i.e. mature religion (religion as doxology). In this case religion fosters purposefulness and responsible action. Theological analysis of God images seeks to assess the person's understanding of God by determining the content of his/her God images. These develop through a person's experiences of God in real-life events and by reading Scripture.

However, when diagnosing people, the counselor should recognize that he/she has their own image of God based on their own experiences; he/she has an ecclesiastical tradition; he/she should be sensitive to the counselee's concept of God; and the diagnoses should not be ethical, i.e. be concerned whether it is bad or good. As the person tells his/her story, the counselor should do a story analysis of God images, i.e. funny stories, tragic stories, romantic stories, ironic stories, dramatic stories and therapeutic stories (Louw 1998:332). Apart from the story analysis, there are four assessment models, i.e. the metaphorical model, the experiential theodicy model, the pastoral semantic model, and the thematic model. The counselor can choose to use any of the models, depending on the circumstances that the counselee faces. For instance, the experiential theodicy model would be best in crisis counseling.

Pastoral counseling, however, cannot and does not claim to solve all human problems. But its purpose is for a person to develop the most effective Christian/biblical way of responding in trying times, by applying faith sources in order to live more purposefully and meaningfully with suffering and pain.

Egan's model and the anthropological foundation of humans, Louw (1998:355) designed a stage model for the strategy of pastoral counseling (as represented below).

	Stage 1	**Stage 2**	**Stage 3**	**Stage 4**
Purpose	-Build contact(trust) - Self-insight - Self disclosure	-Problem analysis -Paraphrasing -Integration of information - Development of perspective	- Responsible behiviour -Decision-making -Goal setting -Programme designing	-Organic use of Scripture -Discovery of meaning - Awakening of hope - Maturity in faith
Anthropology	affective	Cognitive	Conative	Normative
Human function	Experience	Reflection	Decision, action	Believing Hoping
Response	- Empathy - Support - Probing	- Interpretation - Diagnosis - Questioning - Information	- Challenge - Confrontation - Information	- Edification - Empowerment

The different stages in the stage model do not mean that each stage is demarcated clearly from the other, without overlapping. There are always cases of overlapping between stages during the counseling conversation. There is no way for a human being to be compartmentalized, which may be the wrong impression conveyed by the stages. Also, one stage does not automatically lead to the next, as the stages are interwoven. They are just a compass indicating the direction counseling should go. In African pastoral counseling, where counseling does not adopt the Western professional approach, it is valuable to know the right questions to ask and to be competent in story/narrative analysis and worldview, so that you can cope with possible roadblocks. After pastoral diagnosis, in our case of the HIV/AIDS affected person(s), I should proceed to counseling in Africa. But what is HIV/AIDS counseling and what does it entail?

5.4 Pastoral counseling as the responsibility of all believers

"Pastoral care" and "pastoral counseling" are phrases that are often used interchangeably, though they can be differentiated. In speaking of pastoral care, pastoral counseling is implied or assumed. One cannot be a pastoral caregiver and not be a pastoral counselor. Theologically, these activities are referred to as *cura animarum,* which describes "a very special process of caring: caring for human life because it is created by God and belongs to God" (Louw 1998:22-23). However, *cura animarum* should not be mistakenly perceived as only the pastor's responsibility. This understanding of *cura animarum*

overlooks the central role of faith community (*koinonia)* . Some HIV-positive young people may prefer disclosing to the pastor or church people, but not to their families

Thus pastoral care and counseling are the responsibility of all believers. Hence for pastoral care to incorporate the notion of *koinonia,* it may be necessary to precede the terms "care" and "counseling" with the word "Christian", so that it becomes "Christian counselling". This emphasizes the central role of *koinonia* in order for people not to have misconceptions by associating pastoral care with "pastors" only. Besides, when one speaks of "pastoral," it implies pastoral from the perspective of Christian theology. Louw (1998:260) emphasizes that:

Although it is very difficult, and even dangerous, to distinguish between the pastoral roles of believers and the clergy, it is helpful to bear in mind that pastoral counseling does not mean a distinction in character between counseling offered by clergy and the pastoral care offered by believers. It is more a *functional distinction*, with the accent being placed on the uniqueness of the relationship between pastor - parishioner within the context of the *communio sanctorum*. The principles, which undergird pastoral counseling, are applicable to all other forms of Christian counseling.

The counseling is listening to and interpreting people's stories. People seek counseling because they need someone to listen to their story. And the story is tangled, it involves themes, plots and counter plots. The story itself is an interpretation of experience and one seeks a counselor because the interpretation has become painful.

Van Dyk (2001:201), referring to HIV/AIDS counseling, states: The counselor cannot change the adversity inherent in the client's status or events that caused it. The counselor's sphere of influence is defined by the aftermath of the disclosure of the HIV-positive status – how the client reacts, how significant others react, and how these reactions might impact upon symptom development, the course of the disease and the quality of the client's life. The aim of counseling the HIV – infected individual is therefore to focus on life beyond infection and not to dwell unnecessarily on the constraints of the disease. The counselor's role is to facilitate the client's quality of life by helping him or her to manage problems, to effect life enhancing changes and to cope with the kinds of problems that will arise in the future. The goal of Van Dyk's counseling approach of enhancing changes in life is sound, but I may ask: does counselors have the ability to enhance such changes, since conversation achieves therapy? I should strongly hypothesize that enhancing hopefulness, i.e. quality of life beyond infection requires a more holistic and assuring approach than Rogerian client-centeredness. Although Van Dyk has a valuable goal, can this client-centeredness be the most appropriate therapy to achieve the goal in HIV/AIDS?

The World Council of Churches' mission and evangelism guide to HIV/AIDS pastoral counseling states: People living and dying with AIDS have spiritual and emotional as well as medical needs. They ask questions related to God and the soul, life and death, condemnation and forgiveness, eternity and transcendence, forgiveness and salvation. They are looking for pastoral counseling, consolation and acceptance. In some places, pastors and churches are the nearest or only resources available in times of crisis and need.

The World Council of Churches' observation about HIV/AIDS counseling is crucial. HIV/AIDS brings anxiety and despair, issue of soulfulness, life, death, condemnation and forgiveness, eternity and salvation to the surface. Furthermore, due to stigmatization and discrimination the individual longs for consolation and acceptance. Therefore to address the situation we hypothesize that pastoral/Christian therapy (Counseling) is a more holistic and reassuring approach. The HIV/AIDS person's longing for soulfulness, life, death, forgiveness, salvation, eternity, consolation and acceptance is provided by a caring faith community *(koinonia)* that graciously accepts and identifies with the person. Christian life, Wislon *et al.* (1996:195) state, is life in community, and the search for better community is central to the network of Christian ministry. Louw (2005:10), in *Mechanics of the Human Soul,* therefore, adds that soulfulness and coping in crisis results from the quality of networking and systemic relationships, which can be provided by *koinonia*.

This argument can rightly be adopted for HIV/AIDS-infected young people's existential crisis. Thus: People cannot cope with many crises in life because they do not understand the mechanics of the processes of networking and relational interactions (the happenstances of life). When they try to utilise the so-called potentials of their soul, they become more confused due to the fact that life itself starts to become intolerable (Louw 2005:10). Louw's argument dismisses the psychological argument of inner potentials, especially in HIV/AIDS counseling and encourages communal (relationships and network) healing, which underlines the *koinonia* healing function.

HIV/AIDS- infected young people in communities blends well with the *koinonia* approach, which brings healing. In addition, the church has the theological grounds and motivation to provide the much needed pastoral care and counseling. Pastoral/Christian therapy (orcounselling) communicates God's identification with humanity in suffering (including HIV/AIDS) through Christ, which is also a more appropriate solution for the HIV/AIDS person than the psychological person-centred approach. Christian hope in Christ may possibly help the person to deal constructively and meaningfully with the HIV/AIDS situation. The centrality of pastoral/Christian therapy to people such as those in HIV/AIDS situation is aptly summed by Louw (1998:7-8):

In summary, pastoral care (*cura animarum*), as has been mentioned, basically means caring for people. The caring is not only the responsibility of the pastor but of the whole faith community (*koinonia)* . The *koinonia* approach, much as the communal approach that utilizes human networks and systemic relationships, should be incorporated in HIV/AIDS counseling. Thus HIV/AIDS counseling, apart from the other premises described above (relationship, facilitation and growth), should be distinguished as counseling that utilizes the notion of community derived from the extended family and community. And the faith community *(koinonia)* should provide the caring function. A *koinonia* approach encourages acceptance and identification with the HIV/AIDS person(s) thereby bringing healing. It dispels stigmatization and discrimination. Furthermore, as the HIV/AIDS young person experiences losses and impending death, pastoral care can help the person to deal constructively and meaningfully with the situation through God's identification with the suffering (HIV/AIDS) through Christ. Thus God is beside the person in his situation as evidenced through *koinonia* members who walk the journey with the person (embodying love and gospel).

The shift of pastoral care from the professional consulting room to the faith community *(koinonia)* is very important for pastoral care in suffering and HIV/AIDS. It creates a link between *koinonia* care and extended family care. Christians are encouraged to care for one another. When young people who are born with HIV infected, the theodicy issue springs to the forefront. Why me God? he/she may not be wrestling with a meaning issue. The why? in fact, should be preceded by who? people want to know "who" caused the HIV infection and "why?" Though they may accept a naturalistic explanation, it is always interpreted within the personalistic (supernatural) framework. Healing among those people therefore may entail shifting from the supernatural worldview (cause and effect) to biblical thinking that does not answer every why question. Thus over and above the theological assessment of God images, faith analysis and religious analysis, a counselor should be able to determine/diagnose the intensity thought patterns (worldview) in order to offer meaningful, effective and relevant counseling to HIV/AIDS-infected young people.

The task of counseling entails building a relationship (counselor and counselee) where the counselor facilitates the counselee's growth. Within the framework however, counseling is equated to divination. The counselor listens to and interprets people's stories and counseling often takes the form of advice counseling (wisdom and direction). But, importantly, HIV/AIDS counseling should take a communal structure. HIV/AIDS counseling is geared towards facilitating the counselee's quality of life by helping him/her to manage problems and to cope after the disclosure of the HIV-positive status. However, hope on life after infection requires a more holistic and reassuring approach than Rogerian client-centeredness. Pastoral counseling therefore is more able to deal with the plight of HIV/AIDS-infected people. An HIV/AIDS person is facing death and he/she asks questions related to God and soul, life and death, condemnation and forgiveness, etc., and pastoral counseling (therapy) is the appropriate discipline that is equipped to deal with these issues (death, ability to instill strong hope and meaning that transcend the present situation and anticipate the ideal).

Pastoral counseling to HIV/AIDS-infected young people transforms their human existence so that victory over sin and death becomes a reality, which imparts meaning to life. HIV/AIDS pastoral counseling is not just a deathbed ministry, where the pastor is sought to minister to a person dying of HIV/AIDS. It is a daily ministry that offers positive orientation to life through eschatological hope. The HIV/AIDS young person suffers from guilt, despair, anxiety, alienation, and the list can go on, but it is only through God's fulfilled promises regarding salvation that "restoration, peace, integration and conciliation" is found. As HIV/AIDS care focuses on the infected person, it is crucial to communicate the message of hope. God's faithfulness (applied contextually), such as, "I will be with you (Mathew 28:20)" and "the Lord is my shepherd (Psalm 23)", guarantees God's presence in the midst of HIV/AIDS uncertainty. As a faithful Shepherd God is always with his people, through gospel wisdom and insight we know that even in the HIV/AIDS condition He (God) is sovereign and knowing. A life surrendered to the arms of God, coupled with this understanding, attains a measure of stability, there by bringing healing. The HIV/AIDS person therefore would live his/her life beyond infection positively, which is crucial for physical healing. So, both horizons of hope (the immediate and future) are merged in pastoral counseling.

Pastoral counseling (i.e. church – *koinonia* care) should not only concentrate on inculcating God, who identifies with people such as those in the HIV/AIDS condition, but should embody the care metaphors.

These metaphors should be perceived in communal terms which challenge and encourage mutual care and interdependence of believers. This practical approach to the infected people foster God-image of God who is a Friend, Partner and Companion for life through the "being there" of *koinonia* in HIV/AIDS-infected young people's situation. In this sense therefore someone who may have tension with the traditional community may find a "hidden nest" among fellow believers. They encourage him and are his companions, thereby replacing the traditional community and extended family healing role.

In pastoral counseling the relationship between the Bible and psychology should be handled carefully. Louw refers to these epistemological sources as being in tension, which he terms "bipolarity". He views this tension as healthy, since these two horizons never merge. Psychology operates from below, while Scripture (revelation) comes from above. The bipolarity can only be resolved through convergence. In the convergence model pastoral care and counseling are viewed as a unique theological perspective, i.e. eschatology determines it. Eschatology signifies our new being in Christ, as well as the revelation and fulfillment of our future in terms of the coming kingdom. Hence pastoral care within perspective inevitably connected to hope. The exercise of pastoral care is a sign of hope to the world. This hope is the fountain of peace and motivation to live in this life, even with HIV/AIDS infection. Within perspectives the Holy Spirit, who is the counselor and comforter, guides and empowers life and emanates from the victory on the cross. The Holy Spirit therefore is central to the perspective model. The eschatological perspective to the HIV/AIDS-infected people provides a horizon meaning, links the person to the faithfulness of God, creates a normative framework, and imparts a unique identity to the counseling act as the counselor acts from a faith dimension. The centrality of the cross and the emphasis on hope in a convergence model is to provide a framework for understanding the suffering of the patient beyond the stigmatization paradigm of HIV/AIDS-infected people, which encourages *koinonia* acceptance and involvement.

Complacency, selfishness and loveless self-assertion. With trust in a transcended God, the community of faith *(koinonia)* should be steered to self-sacrificing service and unconditional love, thereby sharing with those in the shackles of HIV/AIDS infection, hope for the future, gratitude and joy (doxology) for the historical event of the cross. The church should therefore march on into the community and have an impact on people's lives by being God's kingdom's exhibits of mercy and compassion.

CHAPTER 6: Conclusion

6.1 INTRODUCTION

This chapter is in two parts. The first part summarizes the argument of this research and the second part outlines findings and makes recommendations on the issues raised and discussed on the research problem and the hypothesis.

6.2 SUMMARY OF ARGUMENTS

Pastoral counseling is the appropriate approach that can satisfactorily and meaningfully deal with the plight of HIV/AIDS-affected people especially to those who are born with it. The care and counseling is not only provided by the professional pastor but the faith community *(koinonia)* also, from the time a person is diagnosed HIV-positive until death. Thus *cura animarum,* which is a classical formulation of pastoral work, denotes a special process of caring for human life because God created human beings and they belong to Him; it is a congregational task. Therefore within this paradigm the Christian community would view itself as key and central to proving support and healing to HIV/AIDS-infected young people.

Pastoral counseling entails building a *relationship* (counselor and counselee), where the counselor *facilitates* the counselee's *growth*. Counseling is equated to divination. Counseling often takes the form of advice counseling. Specifically focusing on HIV/AIDS counseling, it is geared towards facilitating the counselee's quality of life by helping one to manage problems and cope after the disclosure of the HIV-positive status. However, cultivating hope for a life beyond infection requires a more holistic and promising approach than Rogerian client- centeredness. Pastoral counseling is arguably the best approach that may be able to deal with the plight of HIV/AIDS-infected young people. An HIV/AIDS person faces death and he/she asks questions related to God and soul, life and death, condemnation and forgiveness, etc., and pastoral counseling (therapy) is the best discipline that is equipped to deal with these issues. It meaningfully addresses the issue of death and has ability to instill strong hope and meaning that transcends the present situation and anticipates the ideal. Pastoral counseling to HIV/AIDS-infected people transforms their human existence so that victory over sin and death become reality, which imparts meaning to life. Hence the HIV/AIDS person would live his life beyond infection positively, which is crucial for physical healing also.

When young people know that they are HIV infected however, the theodicy question springs to the forefront. Why me God? But when these people ask the why In fact, the why? Question is preceded by the who? Question; people want to know "who?" caused the HIV infection first and then "why?" Though they may accept a naturalistic explanation, it is always interpreted within the personalistic (supernatural) framework. Therefore, healing among these young people entail shifting the supernatural worldview (cause and effect) to biblical thinking that does not answer every "why" question. Thus over and above the theological assessment of God images, faith analysis and religious analysis, an counselor should be able to determine/diagnose the intensity of thought patterns (worldview) in order to offer

meaningful, effective and relevant counseling to HIV/AIDS-infected people. At times community (relations network) influence plays a very negative role by exerting pressure on the person to conform to traditional practices that conflict with a pastoral/Christian mode of healing. Pastoral counseling within systemic relationships should therefore be able to erect support structures for people who may be cut off from their relations network as deviant due to their Christian convictions. It should be patient with those who oscillate between the two spheres as they count the possible cost of their actions. Thus we should heed Jude's words "Be merciful with those who doubt" (Jude v22). A pastoral counselor should have the following characteristics: non-possessive warmth, empathy, genuineness, listening skills, interparty, respect, concreteness, confrontation, confidentiality and immediacy. These qualities are applicable in any context, but in addition to these, a counselor should be able to listen and interpret stories, be able to listen and read behind the narrated story. Africans do not usually express their beliefs and practices in words as much as they live them, so a counselor should not only focus on the narrated story; he/she should be aware of indicators to probe. And lastly, counselors should be able to probe, comfort, discern, interpret, empathize and edify counselees.

6.3 Findings and Recommendations

This research focused on how a people diagnosed HIV-positive especially to those who are born with it. And the significant others may get healed. Thus it deals with life beyond infection , the aftermath of the disclosure of the HIV-positive status, focuses on how the HIV-positive young person reacts, how significant others react, and how these reactions might impact on symptom development (physical, psychological, social, economical, spiritual), i.e. on the course of the disease, and how the infected person and other people cope. The role of HIV/AIDS care and counseling is to facilitate and enhance the infected person and affected people to cope – from the moment of disclosure until the terminal stage and eventual grieving and bereavement. This therefore means HIV/AIDS care and counseling is not a once-off exercise or a few sessions like, for instance, dealing with a marriage conflict, but a long process of walking the journey alongside the infected and other people – through the stages of diagnosis/sero- conversion, asymptomatic phase, symptomatic phase, serious illness, the terminal stage, and grieving.

However, the journey (from disclosure to the terminal stage and grief) is a long one and it requires other people to be present for support. Thus there should be a model of HIV/AIDS care and counseling that satisfies these conditions – and we have suggested pastoral care.

This research found that, despite the facts in support and takes care of young people who are born with HIV/AIDS as an effective responsive paradigm to HIV/AIDS care and counseling.

Most of the literature concentrates on unconditional love, acceptance, avoiding discrimination, and not to stigmatize, etc. HIV/AIDS-infected young people. In so doing, they would be enfleshing/embodying the gospel like Jesus who loved, cared, accepted and did not discriminate against people during his earthly ministry. Basing on this argument, then, the church or congregations are challenged to care, i.e. to do likewise. This theological locus, though it appears clear in Scripture, overlooks an important issue in the church.

The Continuing Conversion of the Church,

Church mission (evangelism), highlights a way that might steer congregations in this direction, which he calls church conversion. Congregation/church should continually be converted in their practices (not only in gospel proclamation!) so that they can change their attitude in order to be able to practice the "unconditional" – love, acceptance, indiscrimination, etc. – that Jesus demonstrated. Guder rightly argues that the missional church's theology and practice of evangelism should be rethought and redirected to address the contemporary challenges, which include sweeping changes in its institutional structures and practices. However, though Guder focuses on mission and evangelism, the church in addressing HIV/AIDS should also adopt this approach. Conversion entails changing congregations and church institutional practices – how we view our young people with HIV/AIDS. It should be underlined that it is when the church/congregation is converted that it will view its being in the light of Jesus' ministry, otherwise any ministry that is not motivated through pneumatology resulting from transformed life won't last. Hence congregational mobilization should also target members' conversion in order to truly function systemically.

Continual congregation/church conversion in HIV/AIDS has double implications that seem to be under-emphasized and at times ignored in HIV/AIDS care and counseling discourse; Firstly, the church would be in line with God's expectation of his followers "Christ-like, i.e. Christians", who are pneumatologically transformed and act in "word and deed". Secondly, these people would share this message of reconciliation, peace and hope in Jesus with HIV/AIDS-infected young people, who desperately require Christ's soothing.

However, while we are not recommending a kerygmatic approach, we should understand that the framework in which church members may truly conceive themselves systemically as a family is when they are part of Christ's family. Christ's family implies that the church *(koinonia)* would view its ministry of love, care, acceptance, lack of discrimination, etc. as its being and means of sharing God's Kingdom in Christ (eschatology).

Thus HIV/AIDS care and counseling ministry should not only be perceived as bringing healing to the infected through love, acceptance, lack of discrimination, etc. but should be coupled with the promises of the gospel. This combats the prevailing unbalanced over-emphasis of actions (love, acceptance, indiscrimination, etc.) and under-emphasis of sharing of the gospel (God's promises in Christ, i.e. salvation brings healing). Pastoral or Christian healing is about God's promises in the gospel, i.e. promissiotherapy through the conduit of *koinonia*.

This study revealed that the church/congregational family system is depicted by metaphors/imagery like family, which emphasizes Christian connectedness. And as a system, the church is made of Christians attached or connected as a unit. This system (i.e. communion of believers – *koinonia)* entails that the members' experiences - sorrows, pains, joy, etc. – are shared. The *koinonia* m(system) principle compels them to identify with one another in all circumstances. They are encouraged to carry each other's burden (Gal. 6). Thus if there are HIV/AIDS-infected young people in the church/congregation, members

would be empathetic to comfort and provide for them, which brings healing to the individual and consequential healing also to the whole system.

The church should be treated, which in the researcher's language, should be "converted" (change attitude). Systems theory in the context of HIV/AIDS means that church/congregational therapy should not try to calm the stigmatized or rejected individual, but to change the entire system(congregational attitude) so that rejection and apathy are dispelled.

Furthermore, the concept of homeostasis (balance) in systems theory assumes that systems strive to maintain their identity (status quo). This concept explains the resistance that certain churches/congregations have to incorporating initiatives in response to contemporary challenges like HIV/AIDS. In maintaining the system balance (homeostasis), congregations may prefer having apathetic, uninvolved or downright incompetent members, while creative thinkers and members who challenge others to be involved are quelled.

This study therefore found that the congregational systems approach provides a diagnostic and analytical framework for congregational apathy regarding community and societal issues like HIV/AIDS. Furthermore, it provides ways of congregational therapy (healing through changing its attitude).

It is suggested on the basis of this research that HIV/AIDS should be treated together with other sickness and suffering, otherwise focusing on it exclusively might cause stigmatization. Besides, it is also perceived to be personalistically caused like any other sickness and suffering. A personalistic system perceives disease and sickness as caused by an active purposeful intervention of an agent, who may be human (a witch or sorcerer), non-human (a ghost, an ancestor, an evil spirit), or supernatural (a deity or other very powerful being). The young person who is born with HIV/AIDS is viewed as a victim, the object of aggression or punishment directed against him . Disease does not stem from the machinations of the angry being, but rather from natural forces or conditions such as cold, by an upset in the balance of basic body elements. Thus people, ingrained with the personalistic or supernatural worldview of sickness, though they may hold that a virus causes HIV/AIDS, link or associate it with personalistic or supernatural means.

The association of HIV/AIDS with supernatural causes, i.e. blaming external factors such as witches and sorcerers for HIV/AIDS, has a crucial psychological function. It removes he responsibility from the HIV person, family and society. This hypothesis fits well as a comprehensive explanation within the worldview of sickness, thereby removing feelings of guilt and anxiety. The witchcraft beliefs also resolve the community's need to explain why some people who are at risk do not contract HIV/AIDS. Furthermore, due to HIV stigmatization, attributing HIV/AIDS to witchcraft helps the family not to be stigmatized by the community.

However, this study reveals that attributing HIV/AIDS to supernatural causes also has negative implications. The belief that everything is caused by an external, supernatural beings implies that individuals may not be held responsible and accountable for their own behavior. HIV calls for responsible sexual behavior. In addition, this thinking needs to be seriously confronted and challenged in the case of HIV/AIDS. It creates unnecessary conflict among family (extended) members, since they

are often the ones accused, and yet the cause is known. Therefore, in designing HIV/AIDS care and counseling ministries, this worldview should be addressed fully to dispel denial and encourage status acceptance, which leads to healing.

On focal issues in pastoral counseling diagnosis can be a useful starting point. This study therefore reveals that the challenge in pastoral care and counseling in sickness and suffering (HIV/AIDS) lie in confronting people's worldviews in order to transform and conform them to biblical thinking and worldview (which brings Christian healing). Thus they need to hold tenaciously to God's promises in Christ (gospel) through the enabling of the Holy Spirit, when there may be threatening extended family and community pressure (system). Pastoral care ministry therefore , focusing on congregational systems approach, should be designed with the following in mind:

Congregational *(koinonia)* systems approach, which does not view a believer in isolation but within a congregational network, should be encouraged. The sick and suffering (HIV/AIDS) who embrace biblical thinking and God images should find a buffer or support base through fellow believers *(koinonia).*

Congregational members *(koinonia)* who are the pastoral care providers should be patient with the members who struggle to embrace Christian modes of healing (gospel promises). It is a painful decision that may psychologically haunt one to think that one is in disagreement and conflict with family members and community. As one counts the cost of each decision – cutting oneself off from relationships or rejecting God's promises in the gospel – fellow believers should be patient and persistently encourage the individual. "Be merciful to those who doubt" (Jude 22). Congregational systems *(koinonia)* care, to be sustainable, should always try to assist the affected members to keep connected to their relatives (family and community). When such members successfully through God's grace are able to stand and overcome the crisis, they will be exhibits and testimony of God's victory and hope to the rest of the family and community members, thereby becoming the instrument of communicating the gospel of hope to others. "You are the salt of the world. A city on a hill cannot be hidden. Neither do people light a lamp and put it under a bowl. Instead they put it on its stand, and it gives light to everyone in the house" (Matthew 5:14-15).

7. **BIBLIOGRAPHY**

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