SUBJECTS OF COUNSELLING: RELIGION, HIV/AIDS 
AND THE MANAGEMENT OF EVERYDAY LIFE IN 
SOUTH AFRICA

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HIV/AIDS, Religion and Counselling in South Africa

Is religion relevant for dealing with disease? In spite of his well-known refusal to give a definition of ‘religion’, Weber’s sociology of religion begins with the sweeping suggestion that religious or magically motivated action is a rational social practice, guided by the rules of experience, directed at this-worldly affairs and aiming to enhance wellbeing and long life (Weber 1972: 318). Moreover, Weber argues that the power of religious experts in interfering with people’s everyday life conduct is most directly realised through pastoral care and guidance. This form of religious power to shape people’s care for wellbeing is currently reinforced through the emergence of faith-based health counselling in the context of HIV/AIDS in South Africa. While for a prolonged period the religious response to AIDS was either limited to stigmatising discourses, blaming AIDS victims as sinners or characterised by institutional inertia, during the past decade or so religious activities have gained unprecedented dynamic. Religious organisations are now at the forefront in prevention campaigning and organising care and social support for the diseased; they are running countless support groups and provide medical, psychological, practical and spiritual counselling for people living with HIV/AIDS, their partners and families.

Explaining the difficulties and failures of the South African struggle against AIDS, scholars have pointed to the specificities of South Africa’s historical trajectory (Fassin 2007), lack of political attention to AIDS, delayed comprehensive policies, and lack of funding for education and

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communication, public health institutions and public sector treatment (Nattrass 2004; Schneider 2002). However, even where institutions were in place, information available and levels of knowledge on transmission and prevention rising, rates of infection did not appear to decrease. Moreover, despite the slow but increasing enrolment of AIDS patients on antiretroviral treatment regimes (ARVs), mortality rates continued to rise because of lacking patient competence and treatment adherence. Information about medical facts and their behavioural implications alone seemed insufficient to change HIV-related patterns of practice, which are more deeply embedded in culture, socioeconomic conditions and mute routines of everyday life than health experts believed.

While counselling could have been a solution to these problems, its introduction was characterised by similar institutional inertias. Although AIDS counselling comprises a variety of forms and subjects, its understanding in public health discourse is still largely limited to pre- and post-HIV-test counselling. In 1994, the National AIDS Co-ordinating Committee of South Africa drafted a National AIDS Plan in which counselling was acknowledged as an important strategic component (Richter 2001: 149). Even though the Plan advised that counselling be implemented ‘across the continuum of care’, i.e. prior to infection, before and after testing, through the various stages of disease and after death, governmental efforts mainly crystallised around Voluntary Counselling and Testing (VCT). While by 2000 VCT was widely offered, remarkably little governmental attention was paid during the nineties to developing more comprehensive counselling services. Nineteen unevenly funded ‘AIDS Training, Information and Counselling Centres’ (ATICCs) were established to cater for the counselling needs of the whole country, while the Lay Counsellor Project, founded in 1996, set the unassuming goal of recruiting, training, and employing thirty lay counsellors in each province. Only in 2000 the policy process concluded with a comprehensive plan for regulating training and standards (ibid.: 150, 153). \(^1\)

\(^1\) According to the 2005 South African National HIV Survey report (Shisana et al. 2005), 30.5% of the members of the adult population have done an HIV-test at least once in their life. Females were generally more likely to have been tested than males, as were married respondents compared to unmarried individuals. About 80% of all respondents were aware of a place where they could go for a test and a large majority of those who did test were satisfied with the services they encountered. However, the report does not allow for final conclusions about how successful VCT campaigning eventually is. Many South Africans are being tested for HIV in the context of other
Compared to the standard repertoire of health education such as radio and TV broadcasting and public billboards—forms that represent some kind of ‘distance counselling’—counselling sensu strictu is based on the face-to-face interaction between the counsellor and the counselled subjects. It allows for a more profound inculcation of health messages and is often organised in a follow-up process, which deepens the educational effects and social control. Counselling thus ushers in two major changes: it intensifies education, and it amplifies the range of problems perceived to require external therapeutic intervention. Because of their standardised format, it is almost impossible to address individual specificities through generic campaigns. Counselling, on the contrary, allows for the taking of these specificities into account and for defining individualised problems and solutions. By negotiating and objectifying this set of problems, the counselling process acts as a means of producing ‘HIV-positivity’ through a regulated ensemble of discursive practices.

The need for counselling was reinforced by the increasing enrolment of HIV-positive people on ARVs. Before enrolment patients enter yet another round of four counselling sessions carried out by professional or lay medical personnel at the clinics. The purpose of these sessions is to give patients the skills necessary for successfully living on treatment, and to educate them about AIDS: about symptoms, their meaning and how to react to them, bodily processes, the properties of their medicine, acceptable and non-acceptable side-effects and their treatment, opportunistic diseases, proper nutrition etc. These sessions are the production sites of ‘medicalised identities’ in which the medical meaning and practical requirements of living on HIV-treatment are systematically organised into the daily routines of chronically ill persons.

However, it seems that rather than through governmental efforts it is in the religious field that the concept of counselling ‘across the continuum of care’ is increasingly being put into practice. One major reason for this is that with regard to the self-relationships that individuals are incited to establish in counselling settings, that is, to what Foucault termed ‘truth regimes’, and to the discursive techniques and vocational medical examinations, specifically in the course of ante-natal exams for pregnant women (34.1%), and the 42.7% (ibid.: 83) who stated as a reason for getting tested that ‘they wanted to know their status’ might attach meanings to this statement that significantly diverge from simple conformity with the preventive and educative rationales that the campaign promotes.
identities of counsellors, there are a number of elective affinities between the traditional religious practices of pastoral care and spiritual guidance and the more mundane concerns of medical advice. Against this backdrop, the aim of this article is to tease out these affinities and to thereby capture how religious organisations contribute to the re-shaping of concepts of responsible selfhood and counselled subjectivity. I argue that AIDS counselling is fundamentally concerned with producing, inculcating and disseminating new notions of moral responsibility and that its promotion by religious organisations is a response to the shortcomings of governmental programmes. The analysis is based on guided interviews with HIV counsellors and participant observations, carried out in Xhosa-speaking townships of Cape Town in 2006. Conceptually, my research is situated within the broader confines of a cultural sociology of public interventions and social technologies that seeks to identify the mechanisms whereby human subjectivities and conduct are moulded and managed in relation to governmental techniques of power.2

The Rise of the Counselling Society: Therapeutisation and the Professionalisation of Help

Sociologically, the idea of counselling, i.e. the voluntary search for advice that turns people into clients and help into control, is certainly far from new. What is new about counselling in modern society is that the circumstances under which people feel or are made to feel incompetent have multiplied. The enhanced need for professional advice is a direct corollary of the growing complexity of modern social life. According to many theorists of modernity (see for example Luhmann 1997), much of this complexity is an outcome of the process of functional differentiation, popularly depicted in the phrase that ‘modern individuals know almost everything about almost nothing’. Hence the need for seeking expertise in the vast field of experience where we know too little for making the ‘right choices’. Following Meyer, the modern concept of actor-hood is characterised by the cultural expectation enjoined upon

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2 Notwithstanding the significant differences between the various denominations and theologies, I am trying to advance a general argument, putting more emphasis on the common characteristics of the ‘subjects of counselling’ than on differences between practical and theological approaches.
all kinds of actors to situate themselves within far-reaching networks of counselling and expertise (Meyer 2005).  

The emergence of modern counselling therefore rests on the organisation of certain types of practices through *professionalism*, the corresponding construction of ‘*experthood*’, and thus on the differentiation of cultural knowledge. This knowledge is incorporated in ‘tool kits’ of habits and skills people employ as symbolic vehicles for persistently ordering action through time (for this concept of culture, see Swidler 1986: 275). Schütz and Luckmann (1979: 363) distinguish between *common knowledge*—knowledge that everyone has at hand for coping with the problems of life—and *special knowledge* that relates to specific problems. The latter is only passed on to those who are professionally concerned with such problems through processes of secondary socialisation.

It would be futile to make a comprehensive list of all the areas of modern social life which counselling has re-shaped in one way or another. Theorists of reflexive modernisation even suggest that this transformation through which social processes are increasingly mediated by widely distributed networks of technical expertise presents the most distinguishing feature of modernity in its current phase (Beck/Giddens/Lash 1994). In relation to technologies of care for the wellbeing of bodies and souls, this transformation is expressed in the overall tendency towards ‘*therapeutisation*’. In the broader context of their theoretical elaborations on the social construction of reality, Berger and Luckmann developed a concept of therapy, which is stripped of its more narrowly defined medical connotations to refer to a specific mode whereby the adherence of human subjects to institutionalised meanings and definitions of reality is secured (Berger/Luckmann 1969: 121). As an institutionalised method of social control, therapy ranges from exorcism and pastoral care to psychoanalysis and myriad other types of pedagogical and problem-solving counselling. The critical dictum of ‘therapeutisation’ translates this concept into a sociological

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3 The term modernity as an interpretive category is broadly taken to refer to diverse cultural configurations in which the quest for autonomy has been transformed into the generalised (expectation and) obligation to autonomy. The close associations of modernity with functional differentiation and the reflexivity of social practice reveal that modernity and counselling (broadly conceived) are to some degree coextensive.

4 This list would comprise issues such as family and marriage counselling, dietetics, career counselling and household-level family planning. The differences between counselling and education are often rather gradual than qualitative. The increasing tendency within modern society to subsume people under diverse regimes of help and control has been famously captured by Ivan Illich (1996) in the notion of ‘*expertocracy*’. 
diagnosis according to which we are witnessing a rising extent to which people subject themselves to the regulatory and helping regimes of control by experts.

Importantly, within the domain of everyday life there is a particularly closely-knit and elaborated network of counselling relationships that focuses on health, psychic and spiritual wellbeing. Through these relationships the human body and soul are turned into objects of intensified efforts of knowledgeability, management, control and supervision. These efforts are triggered by a shifting focus of medical practice from ‘illness’ towards a concern with ‘health’ and thus to preventive therapeutic strategies, health maintenance, health promotion programmes and chronic illness management (Moreira 2007). The expansion of counselling practices around HIV/AIDS in South Africa articulates these shifts. In the following section, I describe the involvement of religious organisations in the current social landscape of HIV/AIDS counselling.

Fighting HIV/AIDS through Religious Counselling in South Africa: A Phenomenological Sketch

The above arguments have mainly been taken to reflect recent Western developments. The fight against HIV/AIDS, however, has inadvertently drawn some developing countries into the same dynamic, with the interrelated processes of globalisation, development and modernisation and the ways people engage with them, being the principal forces of change. People in Cape Town make routine use of the expert systems surrounding HIV/AIDS, and the more the self-reinforcing spirals of supply and demand expand the stronger the cultural expectation to seek advice from experts. The very meaning that popular discourse affords the idea and practice of HIV counselling, however, greatly varies and clearly exceeds the definitions of public health discourse. Grasping this variety forces us to move away from the medical world of clinics, to ‘follow the people’ (Marcus) and tracing the diverse social encounters in which HIV-related issues are rendered subjects of intervention.

In everyday life, people get in touch with HIV/AIDS counselling in various ways: On the one hand, it can take place in the context of prevention campaigns; for example many of Cape Town’s churches run youth groups meeting regularly under the auspices of a pastor or a church-affiliated youth worker and discussing AIDS in the broader context of intimate relationships, (unwanted) teenage pregnancy, abstinence
and fidelity, sexually transmitted diseases, and reproductive health. The charity wings of churches or other faith-based organisations (FBOs) use similar organisational forms within church or neighbourhood communities. Furthermore, family members of HIV-positive people often seek technical, practical and spiritual advice about how to deal with them from their pastors or other church-based lay counsellors.

On the other hand, religious actors are also involved in pre- and post-test counselling. Within the South African slogan ‘Know your status!’ the exclamation mark signifies an ethical demand, turning the practice of testing into a *dispositive of truth* (Hondrich 1988). The act of handing over a small quantity of blood to be checked for HIV-antibodies in scientific labs as a practice revealing the truth about oneself is thus invested with moral significance that has far-reaching implications for the interpretation of life history. Encouraging people to get tested is part of the standard repertoire of FBO counselling in Cape Town. Rhetorically, these efforts are framed exactly through such claims to ‘knowing yourself’, and theologically underpinned by the declaration that while one might hide the truth from oneself, God knows it anyway. Counselling therefore translates the medical truth into a sexual truth, which much in the same way cannot be hidden from God. Prince and Geissler (2007: 144) argued that for the Luo of Western Kenya the Christian engagement with AIDS contributed to drawing sex from the darkness of the night into the daylight of discourse. The same holds true for Cape Town’s Xhosas.

Pre-test counselling may take place in the FBO premises or at a person’s home. Many FBOs and churches also collaborate with local clinics by sending counsellors to test-sites. The overriding purposes of these sessions are to prepare people for the test and to strengthen their conviction that they are doing the right thing, whatever the result. The test is followed by post-test counselling, which aims at advising people on how to cope with the results. This includes very strong psychological but also spiritual and practical components. If the result is negative, people are encouraged ‘to stay negative’, i.e. to take the result as an opportunity and to henceforth live a virtuous sexual life in religious as well as medical terms. For married people, virtuousness naturally equals marital fidelity while unmarried youth are invited to follow the path of salvation through opting for ‘secondary virginity’. If the result is

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5 Most of the unmarried people who use religious test-related counselling services have already had sexual intercourse. The practical, albeit theologically problematic,
positive, the need for assistance is usually overwhelming and not to be satisfied within a single session. The first session is primarily dedicated to the psychological and spiritual dimensions of coping, to exploring together with the individual the psychological benefits of selective disclosure, and to preparing her or him to be counselled by others within their social networks. Post-test counselling sessions are therefore the first sites where the social life of HIV-positivity is being arranged. While for medical professionals the job of counselling is usually finished once the client has left, religious counsellors are intervening in the practical organisation of the daily lives of HIV-positive people in very different ways, as the following examples will demonstrate.

Throughout my field research I have been closely following the activities of Melisizwe, a forty-one year old self-inspired religious AIDS activist from the township of Khayelitsha. Melisizwe, a former member of the ANC’s military wing, converted to Pentecostal Christianity in the small neighbourhood church ‘El Shaddai’ in the mid 1990s where after a while he was ‘ordained’ as a lay pastor. The religious vocation to giving love and compassion and the need to connect his social and political activism with new objectives have later become the foundation for his choice of engaging in the struggle against HIV/AIDS.

For a number of years he regularly organised HIV/AIDS information workshops with the help of some HIV-positive women from the neighbourhood. The women, just as he himself, have received expertise on AIDS through training workshops in the local office of the Treatment Action Campaign (TAC); with these women he is also undertaking workshop tours through cities and villages in his native Eastern Cape Province at least twice a year. In January 2006 he founded an AIDS support group whose members meet once a week in a tiny community hall and transformed themselves into some of the most proactive contributors to the already vibrant scene of local civil society activism. In

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6 All personal names in this article have been changed.
7 The Treatment Action Campaign (TAC) is one of the biggest AIDS social movement organisations worldwide. It is primarily dedicated to empowerment, fighting stigma and spearheading the struggle for the universal provision of antiretroviral treatment (ARVs) through the public health sector.
one of our meetings he passed me a copy of a newly produced flyer of his church community; not accidentally, the only non-sacramental service the flyer mentions is HIV counselling. In response to my question of what he is actually doing when offering counselling, he recounted the following story:

One day, Spiwo, a friend from his church congregation, had been called to the house of his forty-eight year old mother because she had become seriously ill. His mother told him that in the course of the medical exams she had been tested HIV-positive. Suspecting her husband, a long distance truck driver, of entertaining sexual relationships with other women during his long periods of absence, it seemed clear to her that it was him who had infected her. Spiwo decided to inform his older brother and his younger sister. His siblings are getting so furious about the alleged behaviour of their father and its consequences that they decided to ask him to leave the house once and forever as soon as he returns from his current tour. When their father is in fact being confronted with the situation on his return, he rejects their version of the story and instead accuses his wife of sexual infidelity during his absence, a stance fully supported by his own siblings. While Spiwo tried to mediate between his own and the father’s family, his own siblings were not ready to compromise and the situation escalated. When Melisizwe eventually emerged at the scene the conflict had advanced to the point that both parties were unwilling to talk to each other. He was thus left with no alternative to talking to them individually. He recalls,

(…) I said to the husband, man, you have to be honest to yourself and Jesus will forgive you. And then the daughter and the son, I said to them, who are you to judge your father, and also to the mother I said, yes, you are in pain but are you free from sin? We all have sinned. Nobody is free from sin. What you must do is you must feel the pain of the other. You must love the other. I said you have to talk and to listen to your husband, and the children, you have to be there for your parents. And so I prayed with them, I prayed with every single one of them. Then I organised a big party, with lots of food. They all came together and everybody was crying. The father is back in the house now and he promised to me that he will do an HIV-test and support his wife.

The story is remarkable both for its highly typical unfolding (it could have been taken from a textbook on the social context of AIDS in South Africa) and outstanding resolution. For those involved it began when Spiwo’s mother fell ill, having had a serological test and an ensuing suspicion of having been infected by her husband. Since AIDS is
a communicable disease, the event of the mother’s illness opened a space for speculations about the past. The mushrooming of speculations invariably transforms the biological entity of the virus into a social agent, producing patterns of blame and suggesting scripts for collective illness narratives such as the one above. While the fear of being abandoned and left with no means for survival often prevents women from being openly confrontational with their husbands or even from disclosing their own test-results (Burchardt 2007), Spiwo’s mother confided in her children. The fact that eventually her children are pushing the conflict to the extreme appears to confirm that they were prepared to care for their mother’s livelihood. This support and the relative negotiating power it affords her seem pivotal in ‘persuading’ her husband to subject himself to Melisizwe’s counselling efforts.

What was conspicuous about his way of narrating this event was his difficulty to verbalise of what his intervention eventually consisted. For him just as for other lay counsellors who are not academically trained, counselling consists of a flow of speaking and listening. It is a mode of engaging with the other that remains within a pre-theoretical, practical consciousness in which a shared cultural knowledge and collective norms of sociality rather than psychological counselling models come to bear. In the above example, his assignment is to moderate the re-creation of trust and mutual support among family members in a situation of overt conflict.

Central to these conflicts is not merely the fact of suffering itself but competing claims to truth: the truth about the responsibility for the ailment, about intimate bonds, love and sex. Although Melisizwe might think that it was most likely the husband who infected his wife, his main objective is not to reveal this truth. Instead of staging a collective confession ritual, he persuades everybody to critically reflect upon himself. The primary objective is foregrounding mutual obligations and duties that allow the family to stay together; here, HIV counselling is tantamount to family counselling. Through the individual conversations, and—in his view—the transformative power of prayers, he prepared the family to accept that the best way of dealing with the illness is restoring supportive family relationships. These agreements are then ritually ratified through the gathering as the practical enactment of the renewed family contract and their mutual forgiveness. In conversations

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8 On family conflicts in the context of AIDS in Tanzania see Dilger 2005: 94f.
with other residents of Town II, many repeatedly referred to Melisizwe as ‘a man of faith’. It seems that the power to effectively influence the conflict rested not least with the authority that being ‘a man of faith’ affords him.

It is evident that the object of HIV-counselling is not limited to affecting the psychological coping, knowledge, attitudes and practices of individuals. Often counselling attempts to interfere with social relationships, i.e. family networks, or typically also intimate relationships between women and men. This latter case is manifest in the narrative of Nokubonga who works as an HIV-project coordinator and counsellor for the small health-service-oriented FBO ‘Phakama’. When Phakama was founded in 2001, Nokubonga began as a volunteer. Being a professional but unemployed nurse, she already had extensive experience and expertise in providing medical care. Later she improved her capabilities by participating in a training course for home-based caregivers, through the so-called DOTS training for tuberculosis treatment, and eventually by becoming an AIDS lay counsellor through ATICC training in 2004. The project started by sending a handful of caregivers to the local clinic where they would be referred to infected individuals or already bed-ridden AIDS patients to assist them with their daily struggle for survival. Later, they founded an HIV/AIDS support group and a more generic women’s support group. Nokubonga has since become the director of the organisation. The role of personal faith for her work surfaces when she asks herself how she manages to deal with all the hardship that her work imposes upon her: ‘I am looking after the project, I am looking after those children who don’t get paid, all these things come back to me, and then I am busy with proposals. But God helps me because sometimes I ask myself, how did I go through here? But then I am a Christ believer’. Out of this religious inspiration she also decided to volunteer for ‘AIDS Response’, an organisation that aims to mobilise churches to engage with AIDS. Soon she notes the lack of activism within the Pentecostal field, and being a member of the Pentecostal ‘United Apostolic Faith Church’ herself she perceives it as her natural mandate ‘to start at home’. ‘There’, she explains, ‘I also have to use the tactics from counselling and things like that, but

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9 The WHO-endorsed DOTS (Direct Observing Treatment Surveillance) Strategy is a labour-intensive part of the fight against TB, based on the control and counselling of patients by regularly visiting primary healthcare workers.
in these churches it is easy for me because I use the bible. If they say “no, we don’t want to deal with that”, I go to the bible and ask, “what did God say about love?” Then it is easy to capture them.’

Within Phakama, the quest for counselling emerges as the caregivers are increasingly struggling with patients who deny their disease and refuse to adopt the necessary ‘healthy lifestyle choices’. As a result, their health status rapidly deteriorates. In such cases, the caregivers inform Nokubonga and she visits them for face-to-face counselling at home. Being asked to describe the circumstances of HIV-counselling in greater detail she recounted the following incident: One day she was called by the support group coordinator to help her with a case, which apparently the coordinator felt incapable to handle. Pumzile, a man in his forties, seemed unable to come to terms with his anger at his infection. Convinced that he had been infected by his girlfriend, he had stated in various group discussions that ‘there is nothing wrong with sleeping without condoms because I am already infected’ while, as he notes, he ‘hasn’t been born with HIV’. His anger turns into a desire for random revenge by infecting others, which would at least give him the satisfaction of ‘not dying alone’. Subsequently, Nokubonga decides to visit him at home. She listens to him as he repeats his arguments to her and responds as follows:

Then I said, listen, yes, it is alright. But tell me, when you think you give it to somebody, what do you think about your body? Your immune system is already low. So the more you give it to somebody the more you reduce your CD4-count. How can your immune system then fight the virus? Then he says, ‘it doesn’t matter because I am already dying.’ Then I said, when did your doctor tell you that you are HIV-positive? And he said, ‘in 2003.’ I asked, how much time were you alive afterwards? And he says, ‘many years.’ And I said, so why do you want to kill yourself? ‘But Sisi, this girl gave this to me, and she is very healthy.’ (...) Then I said, maybe you didn’t get it from her! (...) And he just said ‘ya ya ya, Sisi.’ Then later he came to my office and said, ‘Thank you Sisi, thank you very much. I love my partner and I won’t spread this thing. From now on I tell my partner we must use this thing.’

Similar to the case of Spiwo’s mother, the issue of blame looms large within the horizon of Pumzile’s thinking. Even four years after discovering his status and despite having received information and emotional support as a regular member of a support group, he is still haunted by questions of guilt. Although the relationship to his girlfriend has survived the difficulties related to HIV-disclosure within the couple, it appears to be continually stressed by the shadow that his restricted future life
perspective throws into the present. Previous to counselling, Pumzile saw himself as a ‘victim of AIDS’ whose past life circumstances were essentially defined by others and therefore beyond his own control. Through the comment that he has not been born with HIV he faithfully suggested that the harm has been done to him through events he was unable to affect. The structure of the relationship between social reality and individual agency of the past is being projected into the present and a radically shrinking future. Nothing of what he is doing with his life—save the wish to alleviate his despair by ‘sharing’ it with others—has any real significance since he is ‘already dying’ anyway. Death has completely invaded life and logically forecloses the possibility of constructing a subjective life project—until the experience of counselling. Through the counselling conversation, Nokubonga provides Pumzile with medical information about the consequences of his sexual behaviour, thereby directing his attention not to what he is doing to others, but to his own body. More importantly however, the mere fact that he is still alive is vested with a morality of hope, reconstructing a perspective for positive life projects that his fatalism had shattered. The counselling discourse articulates an ethical imperative to assume the responsibility for the possibilities which ‘the fight of his body’ offers him. At the end, Pumzile accepts Nokubonga’s advice; given the force of his prior rejection to do so, this choice exhibits the radicalism of a personal conversion.

In this section I have tried to show how faith-based HIV-counseling, far from being limited to test-related interventions, emerges as a highly flexible and versatile arrangement powerfully interfering with the experience of HIV/AIDS and the ensemble of interpretive and ethical categories on which this experience is based. This flexibility manifests itself in relations to the social relationships it attempts to affect, the practical purposes and techniques, and significantly, the types of knowledge it incorporates. Faith-based counselling creatively intermingles religious knowledge with medical expertise and communication skills. All these skills and knowledge are acquired in trajectories of secondary socialisation to constitute a variously defined status of ‘AIDS experts’.

The symbolic economy of the therapeutic enterprise thoroughly rests with the recognition of this status by the counselled subjects. Moreover, in terms of the mechanisms that make counselling effective, in other words: that ensure that people do what the counsellor wants them to do, counselling interventions consist of complex mixtures of education, information, and persuasive talk. Melisizwe appeals to his client family
through the truth of the Christian ethics of love and compassion. Here, the fact that the family’s adherence to this truth is a precondition to the success of the intervention reveals the sublime but nevertheless forceful proselytising nature of Melisizwe’s approach. What Nokubonga places at the centre of the counselling interaction, on the contrary, is the knowl-
edgeability of the client’s physical and sexual body and the objective possibilities for a positive life project through ethical sexual practice. In both cases, counselling works to enlarge the range of objects that are being enlisted in the therapeutic regime through the healing force of conversation. For Melisizwe, it is the whole matrix of familial relationships that needs cure, while Nokubonga’s intervention effectively serves to intensify the medicalisation of Pumzile’s sexuality. Regardless of the different empirical settings and practical aims, however, the informative, educational and persuasive aspects of counselling interactions invariably reflect a process of the inculcation and dissemination of concepts of moral responsibility for which faith acts as a symbolic lever. Melisizwe reinstates Spiwo’s family as a community of care, whereas Pumzile subjects himself to the ethical imperative of hope inherent in both, the knowledge he receives and the means Nokubonga employs to instil a sense of ethical selfhood.

Very often, counselling is not a one-off encounter but rather organised as a follow-up process, while the practical issues largely remain the same or expand: adhering to the treatment regime and a healthy diet, abstaining from smoking, drinking alcohol and unprotected sex, building a supportive social network, overcoming lethargy by promoting self-activation, acquiring skills for economic security through employment, and above all, shaping a new identity. This is the moment when long-term counselling relationships are established. The case of Pumzile has already given important hints as to how counselling may function to initiate transformations of the self. On the basis of this broader ethnographic picture it is now possible to gain a better theoretical understanding of the intrinsic relationships between religion and counselling, and of the ways religion and psychology are infused within the process of transforming ethical selfhood. Reformulating and specifying some of the comments I made in the context of my discussion on ‘therapeutisation’, I argue that religion and health counselling converge in turning an enlarged notion of health into an objective of salvation. Faith-based counselling transforms the ‘therapeutic gaze’ into heterogeneous modes for people to scrutinise and act upon themselves, and thus into creative forms of ethical subject-formation.
Between Religion and Health: Post-religious and Post-secular Forms of Ethical Subject-Formation

People’s practices are guided by collectively negotiated meanings of the situations within which they are placed. While under normal circumstances meanings are relatively stable, crisis of meaning and ontological security may arise from critical experiences such as HIV infection. The counselling process may therefore be construed as the social space within which the meanings of disease, and of living with it, are established (Berger/Luckmann 1969: 166). In that aspect it bears remarkable resemblances to religion in providing the symbolic resources for making sense of subjective experiences. If the meanings of experiences are to persist in time they typically require the support of what Berger had called ‘plausibility structures’: social relationships with others who confirm and legitimate the ways we perceive, evaluate and act in social life and with whom we intersubjectively (re-)construct certainty by linking experience and expectation (Berger 1967). As a means to this end, the counselling relationship imitates and partially replaces the religious community (Berger/Luckmann 1969: 169), while the specific case of religious counselling appears to combine the ‘benefits’ of both types of plausibility structures.

However, since HIV infection is a chronic disease its ‘social treatment’ cannot be modelled according to Berger and Luckmann’s general sociological model of therapy as re-socialisation and re-integration into society (ibid.: 121f.). It rather presents the special case of what the same authors have called ‘metamorphosis’: the construction of new identities and personal transformations that, compared to the rather soft shifts in the definition of subjective reality in everyday life, appear as all-encompassing (ibid.: 168). Counselling relationships, just as psychotherapies, can be seen as the cultural ‘laboratories’ for enacting such transformations. Counsellors are the ‘significant others’ who lead clients into their new reality by virtue of identification of the latter with the former. Counselling constructs the new subjective reality of the client through the objectifying force of language and conversation, especially since it draws on one of the most powerful reality-constructing techniques of conversation, the confessional practice (ibid.: 165).

The historical archetype of metamorphosis, however, which all other secular forms of re-socialisation and identity formation qua therapy have imitated, is religious conversion (ibid.: 169). Conversion draws the individual into a process of personal transformation in which life is reorganised
by breaking with the past and projecting a radically changed present into the future. It thus creates new temporalities of life, i.e. new linkages of past, present and future that closely resemble how social and temporal structures work to constitute new models of subjectivity in secular counselling settings. In this volume, Nguyen shows how conversion is mediated by confessional technologies, refashioning the self as discourse in HIV treatment programmes. For understanding the relationships between religion and counselling in South Africa, however, it is important to note that the ‘experience of conversion’ as articulating personal transformation and ratifying it in time (Martin 1990) is at the heart of the most significant aspect of religious change within African Christianity over the past three decades: the rise of Neo-Pentecostalism (Robbins 2004: 127).

Personal transformation, the key notion around which Neo-Pentecostalism is organised (Martin 1990: 163), implies a step ‘that separates people both from their past and the surrounding social world’ (Robbins 2004: 127). Neo-Pentecostal discourse celebrates discontinuity and organises the importance of disjunctive experiences in and through rituals of rupture (ibid.: 128). Building on his findings in Ghana, van Dijk (2001: 226) even argues that completely breaking with the past and deliverance are seen as key elements in Pentecostalism’s ritual structure. In a more general and fundamentally conceptual sense, it is also this ‘step’ and its temporal implications that I would argue exhibits most strongly how religion has paved the way for the emergence of modern psychological forms of self-transformation.

Within the sociology of religion, Thomas Luckmann (1967) was one of the first to emphasise the increasing importance of psychological counselling in providing individuals with a stabilising moral framework in their search for meaning under the fragmented circumstances of

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10 Many authors have stressed that the emergence of Neo-Pentecostalism in Africa can be explained by its capacities to offer to its followers the symbolic resources for understanding and acting upon the consequences of modernity (Gifford 1994; Dilger in this volume). Gifford emphasises that ‘here members find shelter, psychological security, solidarity. (...) In this new world they can forge a new notion of self, for here they can begin to make personal decisions. (...) In this narrow sphere an individual can bring control, order and dignity’ (Gifford 1994: 531). Moreover, the Pentecostal gospel of wealth and health (ibid: 516) strongly resonates with subjective experiences of suffering and illness (for the case of Ghana, see Meyer 1998), whose objectified expressions it helps to shape. Neo-Pentecostalism can thus be construed as a mode of articulating the contingencies and uncertainties that ensue from African modernity in its various guises, and among which HIV-infection figures prominently.
modern social life. Following Luckmann, the rise of these kinds of regimes of advising people on existential issues reflects a shift of functions away from ecclesiastical institutions; but instead of viewing these cultural changes as simple reflections of the secularisation process, he underscored the religious function these new psychological practices fulfil, and accorded them the sociological status of a transformed manifestation of the religious, a concept driven home in the famous notion of the ‘invisible religion’ (Luckmann 1967).

A similar concern with the relationship between Christian religion and the changing forms of subjectivity is expressed within Foucault’s writings on the production of subjectivity, power, and the technologies of the self (Foucault 1982; 1988; 1993); that is, technologies ‘(...) that concerned the ways in which one should undertake the practical organization of one’s daily business of living’ (Rose 1997: 297). These processes are taking place within historical power relations, i.e. at the intersection of practices of government and practices of ethical self-formation (Dean 1994: 147). The encounter of the two Foucault later defined as ‘governmentality’, as ‘the contact between technologies of domination of others and those of the self’ (Foucault 1988: 19). With regard to the institutional arenas in which these processes unfold, Dean observes that ‘practices of the self’ are manifest in activities of the ‘psy’ disciplines, social work, medicine, education, and established religion, as well as those associated with cults of self-liberation and self-improvement (Dean 1994: 153).

In the context of his discussion of ‘pastoral power’, that is, a form of power whose ultimate aim is to assure individual salvation in the next world (Foucault 1982: 783), Foucault too draws our attention to the changing interrelations between religion and health. The increasing concern with health and wellbeing, he notes, should be understood as a shift in the objective of pastoral power, away from a salvation in the next world and towards the salvation in this world. Similar to Luckmann, he interprets this change in functional terms as a decline of ecclesiastical institutions and the concomitant evolution of new structures that work out the same problem with different instruments (Foucault 1982: 783). Accordingly, Valverde defined the governmentality-inspired study of moral regulation as ‘characterized by the common interest in analyzing post-religious forms of ethical and moral regulatory practices’ (Valverde 1994: viii).

The emergence of HIV/AIDS-counselling appears to reverse this situation, and therefore calls for reconsidering these theoretical
assumptions. I suggest that we conceptualise the relationship between religion and modern psychological counselling as an exchange in terms of two distinct discursive arrangements cross-fertilising one another. In line with the propositions of Luckmann and Foucault, this involves the analysis of how the historical functions of religion have been appropriated and re-articulated by other, newly emerging institutional arrangements, and how they have been changed in the course of this. With regard to counselling, three of these changes are quite obvious: firstly, the shift in the objective of expert interventions from other-worldly salvation to a concern with worldly ethics; secondly, the transformation of the instruments of self-scrutiny through the deployment of techniques originating in psychology; and thirdly, the changing character of the relationship between counsellor and the counselled individual.

Within the South African struggle against AIDS, however, the situation has changed. Religion—instead of being replaced by a concern with health—increasingly concerns itself with health by adopting psychological techniques. It thereby re-claims and re-appropriates the ‘subjects of counselling’ and re-figures the ‘objects of salvation’. The rhetoric, the instruments, and even partially the objective of religious health counselling itself are now informed by psychological discourses of mental wellbeing. In addition to that, FBOs see these practices as parts of broader efforts to build a sustainable community life; even smaller township-based faith initiatives now make routine use of modern social work concepts and speak the language of ‘capacity-building’, ‘social capital building’, ‘community outreach’ etc. In fact, most counsellors and other church-based AIDS activists participate in training workshops where they are educated in how to counsel, run support groups, handle public relations and manage an HIV/AIDS programme according to the insights of management theory and organisational sciences. While tendencies towards institutional isomorphism are certainly at work, I do not suggest that religious AIDS work looks like that of NGOs or governmental agencies. With regard to counselling, I would rather argue that the specificities of faith-based approaches lie in a peculiar

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11 It has often been noted that within the broader historical context of African colonialism and post-colonialism religious institutions played a pivotal role in the delivery of welfare and health services to the general population, a fact that certainly holds for South Africa as well. I suggest that the societal significance of this type of religious engagement has been massively expanded with the arrival of the AIDS pandemic.

12 The term ‘institutional isomorphism’ refers to the processes whereby different organisations are in their practices becoming increasingly similar, either through imitat-
mode of incorporating educative, medical, and psychological practices into the overall pastoral concern with shaping ethical selves. It is in this context that we can trace the emergence of post-secular forms of ethical subject-formation through an analysis of how spiritual and psychological aspects are intermingled through such practices. In the remaining section, I take the analysis further by exploring how by progressively problematising everyday life practices and incorporating them into regimes of self-knowledge faith-based counselling acts as a process of subject-formation. To this end, I draw on the example of the FBO Izandla Zethemba and the narratives of two of their counsellors and delineate the aspects of faith that undergird this practice.

From Despair to Eternal Life: Faith and the Responsibilisation of the Diseased Self

At the initiation of counselling processes, counsellors know about the typical problems of HIV-positive people but not about the specificities of an individual case. Since this is seen as a prerequisite for success, counselling unfolds as a series of self-revelations qua truth discourses by the diseased individual vis-à-vis whom the counsellor acts as the exterior memory of the confessional analysis. Counselling thus consists of successively eliciting personal information, mapping out general choices and measuring them against the particularities of individual life situations. Through these conversations individuals understand themselves through a regime of self-inquiry. Ideally they are followed by the subject embarking on the pursuit of self-mastery and of the successful management of everyday life. The role of the counsellor is to instigate this self-interrogation, mediating how people consider their choices. In this sense, she

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13 I want to stress that the term does not imply assumptions about any kind of overriding secularisation processes of Christianity within the South African context. It solely refers to a certain type of reconfiguring the relations between religion and ethics through the professionalisation of religious care of bodies and souls via the incorporation of practical techniques that have been developed outside of the religious domain proper.

14 Xhosa for ‘hands of hope’.

15 The empirical cases should be seen as reflecting two types of trajectories and corresponding social constructions of the ‘subjects of counselling’ among others; nonetheless they clearly depict quite typical ways of working out the typical social problematic of making moral subjects in the times of AIDS.
acts as temporary proxy of the patient’s conscience. She impersonates this conscience whose interactive construction is the condition *sine qua non* of ethical subjectivity.

These structural patterns are clearly reflected in the cases of Sarah and Martha who are working as HIV/AIDS counsellors for Izandla Zethemba, an FBO dedicated to AIDS work with close organisational ties to a Pentecostal church called Jubilee. The organisation has its base in the township of Gugulethu and is one in a series of FBO-type organisational offshoots the church has created over the years with the aim of optimising the management of its charitable activities. Since Izandla Zethemba engages in ‘outreach crusades’ on a regular basis, the organisation’s activities are well-known throughout the neighbourhood. As a part of the analysis of faith-based counselling processes, I identified two patterns of how faith and biography interact in shaping the professional practice of counselling.

Sarah is a thirty-four year-old single. Having started her activities for Izandla Zethemba as a volunteering receptionist, she has gradually moved up within the organisation and is now employed as a project officer. She is coordinating many of the activities, runs two support groups and offers individual counselling. The fact that she is still a childless single at the age of thirty-four she sees as a major personal accomplishment in a cultural environment dominated by the patriarchal expectation to engage in heterosexual relationships and bear children. She closely associates patriarchal norms of gender and sexuality—polygamy and multiple partnering, in her view the modernised version thereof—with ‘backward tradition’. Against this backdrop, the church is rendered a modern social space neutralising the negative forces of tradition and supporting her struggle for female autonomy. The idea of achieving autonomy through disassociation from backward ‘community values’ by joining the church strongly influences her way of counselling young women on how to organise intimate relationships: as a form of self-inquiry about what they—as autonomous individuals—want to ‘achieve in life’.

Unlike many others who are volunteering for Izandla Zethemba, Sarah has a high level of formal education. She graduated from university with a degree in communication and subsequently started working, first as a lay counsellor for domestic violence at the National Integration of Crime and Rehabilitation Centre, later as a telesales person and DJ for a local radio station. Not being restrained by family
obligations or the limiting implications of couple life, she finds fulfilment in pursuing a professional career. In telesales marketing, she is granted the award for the best saleslady of the Western Cape and earns good money; she enjoys the ‘fame of some sort’ and to ‘get into places with press card and all of those things’ that working as a radio DJ affords her. Until this point her life history might be neatly summed up in the notion of ‘success’. In 2000, however, her life changes when her sister falls ill and reveals to her that she is HIV-positive. This critical experience might have triggered the idea that her individualised striving for personal autonomy through pursuing a professional career ‘was not really me because I really felt empty on the other side’. In her narrative she connects the experience of her sister’s HIV-infection with the decision to join the Jubilee church. Her motivation to enrol in an HIV/AIDS counselling training upon a request from her church she describes as follows:

And I had this passion (…). And I just, if I was counselling people, it was something that I was feeling, it was something I was doing out of my passion. And you know, I think it was what God laid for me, the passion for other people. I didn’t know it was coming from God then. And then this is how I got involved (…). It is just I joined the church you know and I had the skills with me and I knew I wanted to be something, and cause I’ve got passion for people and listening to people as well, people’s stories, which is so interesting, I knew that I had to do something.

Within her new working environment she draws on resources she had acquired beforehand and commits them to a purpose that she construes through the rhetoric of religious calling. When speaking of the counselling process and her clients she continually stresses the need to explain ‘what is happening in their bodies’ and that one has to ‘keep options that people can decide for themselves’. Her clients are thus first of all subjects in need of education and knowledgeability as preconditions to rationality and autonomy.

Similar to Sarah, Martha’s wish to become engaged with AIDS activism has been shaped by family experiences with HIV, in her case involving her cousin-sister and her brother. At that time she was working as a caregiver for HIV-positive children, an activity she perceived as psychologically stressful and exceeding her capabilities. While in this sense her professional experiences are rather seen through the frame of ‘failure’, in giving emotional support to her diseased relatives she feels a moment of empowerment. She remembers that initially because she
was ‘shy’ and ‘couldn’t speak’ she had been scared of being a counsellor until eventually ‘God said, go! I’m gonna put words into your mouth!’ Martha too interprets her inadvertent mental strength in the idiom of a calling. Starting from this incident, she enrolled for generic AIDS training and became a social worker. Later she participated in counselling training upon which she changed her metier. Her approach strikingly conjoins professionalised expertise with religious concepts and the knowledge of everyday life. While she notes in retrospect that she ‘counselling’ her cousin-sister, at the time she was actually using a type of skills she had never been trained in. The following passage reveals more in detail how she frames the counselling relationship:

I told her: ‘You still look beautiful and it’s not the end of the world.’ I don’t know from where did I get those words. And I said life goes on. But you must believe and trust in Jesus, you know. You’ll see you’ll have eternal life. And then she came with me to the church here. I introduced her to everybody, to every of my sisters, my colleagues. And she was one of our members then. That’s when I started, working on my cousin-sister. (...) I live with these people, my brother is also positive. So I’m working at home too. (...) I give people hope. I give them strength. And I when I visit them, I am doing the home visit mostly, I comfort them and I sometimes do this what they call self-disclosure. And see how are they coping at home. And they eat, how do they eat. I make sure that they eat healthy. I always told them how to cook their food, you know (...). So I am doing quite a lot of talk. But (...) when I go to the home visit I am always excited. I don’t know, I am always excited. And I’m like friends with them. They are like my friends. I don’t say they are my clients, you know like I am doing a job and they must be so respectful to me (ironic voice). We’re friends, we speak openly! We speak everything with me, you see, I’m free! I’m free so that they can speak everything. And I give them advice when they want to be advised. So I’m there for them. I am helping them, everywhere.

What does the passage reveal about the relationship between faith, counselling and ethical subject-formation? Firstly, in relation to the Other, the invocation of faith serves to delineate a space in which maintaining health through the rational management of everyday life, i.e. the systematic and persistent orientation of practice towards a valued purpose, is rendered meaningful in the first place. Its primary purpose is to overcome the typical fatalism, despair and lethargy of people after a positive HIV-test, now facing a subjective world of fear. It is in this aspect of ‘overcoming’, where religion—turning to faith—and psychotherapy—accepting the meaningfulness of life—converge to produce an experience of conversion. Through faith and faith-based counselling
HIV-positive people may thus move from despair to eternal life. This invocation flows from the counsellor’s prior experience of personal vocation. Secondly, while other types of counselling often draw on the inherent advantages of an impersonal consideration of the problems at stake ‘from a distance’, faith-based counselling establishes the improbable combination of skilled expertise with personal friendship. And lastly, the relationship involves the promotion and inculcation of a defined set of rational practices. Nonetheless the authority of the counsellor rests less in shaping actions than in shaping subjective wants, and is therefore bound up with the inevitably paradoxical assignment of fortifying the counselled subject’s autonomy by helping control.

In Sarah’s account, the objective of achieving autonomy through faith-based counselling sets relatively clear limits to indoctrination. In Martha’s counselling model, on the contrary, the re-building of the counselled subject’s autonomy is premised on authority. She persistently stresses the importance of ‘not being too soft with them’ when ‘they don’t want to listen to you’, and of directing them to assuming responsibility for the ‘gift of life’ because ‘God didn’t create us to be wasted’. The ideal outcome of this pastoral intervention is that clients replace despair with faith; this is underscored by her satisfaction that several clients have experienced conversion in her church during the counselling process. Her clients are therefore first and foremost construed as subjects of pastoral supervision and monitoring.

With regard to the meanings of cure and salvation, her account reveals a non-reconcilable tension between the biomedical facts of chronic illness and the healing powers of faith. On the one hand, she contends that the primary goal of her work is ‘to see them completely cured’, ‘to go from positive to negative’, and closely associates this with the healing forces of prayer. On the other hand, she is at pains to reject any type of ‘herbalist treatment’ promising a cure for AIDS as unscientific and corrupt. This tension is also implicit in Sarah’s narrative when she recounts how one client asserted she had been cured from AIDS. She responds: ‘I believe that Jesus can make miracles and heal you, but we should go and see your doctor’. This statement spells out the problem of theodicy (why doesn’t he if he can?), uncovering the divergent, and sometimes conflicting, truth claims of religion and science, which Weber (1963) had famously addressed in his intermediate reflections. Since bio-medically AIDS is—still—an inescapable reality, however, it also demonstrates that the power of faith for coping with AIDS lies in acting upon multiple uncertainties but also in its opposite:
in introducing contingency, and thus a possibility of salvation that biomedical discourse forecloses. The specific problem of faith-based counselling therefore revolves around constructing models of intervention that incorporate the productive aspects of both, uncertainty reduction and contingency. By critically oscillating between these polar conditions, the therapeutic enterprise carves out a terrain of meaning and moral imperatives in which epistemology and ethics are collapsed in the process of subject-formation. In the absence of biomedical cure, the discursive arrangement of faith-based counselling guides diseased people in making themselves new kinds of subjects through subjecting themselves to a regime of knowledge and ethical injunctions; it thereby opens possibilities of salvation, which serve as recurrent motivators for engaging in rational modes of ‘conduct of life’.

Life with HIV/AIDS in South Africa takes place in an environment of biosocial risks. Managing these risks requires the sustained exercise of individual authority over changing challenges. To the extent that the practices of counselling result in the successful translation of notions of responsible self-hood into regimes of the rational management of everyday life; to the extent that people therefore reinvent themselves as masters of circumstance, these practices should be regarded as primary sites of cultural change. Within this process, religion is relevant not only because it is accorded an increased social relevance as an institution that assists, advises, helps, and counsels, but also in that it provides a transcendent rationale and a motivational underpinning for ‘living positively’. This reminds us of the numerous ways in which religion acts as a force for structuring the conduct of the worldly and daily business of living, and thus of religion as a force of life (Lebensmacht) that was at the heart Weber’s sociology.

References


