Impact of HIV/AIDS on Children: Counseling and Play Therapy as Interventions for Coping

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Abstract

HIV/AIDS is a global health problem now being considered an epidemic in several countries. It is the fourth leading cause of death in the world. Most of the individuals infected with the deadly virus reside in Sub-Saharan Africa, Latin America, or Asia. This paper describes the impact of HIV/AIDS on children and explores the efficacy of employing counseling and play therapy techniques to assist children infected with or affected by HIV/AIDS cope with the effects of the disease.

The Acquired Immunodeficiency Syndrome (AIDS) was described medically for the first time in 1981 (Howard, 2002; Fleming, Wortley, Karon, DeCock, & Janssen, 2000; Selwyn & Rivard, 2003). The Human Immunodeficiency Virus is believed to cause AIDS (Antoni, 2002; Batterham, Brown, & Garsia, 2001; Howard, 2002). By June 2003, infections had reached 52.5 million (Sibanda, Stanczuk, & Kasolo, 2003). According to Howard (2002) and Sibanda et al.

(2003), most of the infected people live in sub-Saharan Africa (25 million), Southeast Asia (5.6 million), and Latin America (1.6 million). HIV/AIDS is now the fourth leading cause of death in the world (Batterham et al., 2001) and the leading cause of death among young people in the United States (Selwyn & Rivard, 2003).

The impact of HIV/AIDS on Africa has been severe and has profoundly affected political, economic, agriculture/food security, social, education, defense, science, and health issues (Sibanda et al., 2003; United Nations Educational, Scientific, and Cultural Organization [UNESCO], 2003). Children and adolescents have not been spared the horrors of HIV/AIDS, but have been the group most tragically affected by the scourge (Carney & Cobia, 2003; Lindblade, Odhiambo, Rosen, & DeCock, 2003; Mengel, 2003; UNESCO, 2003). As reported in the UN Chronicle (2003), an estimated 3 million deaths of children in 2001 were linked to the pandemic. Moreover, at least 13-14 million children have been orphaned by HIV/AIDS since the beginning of the epidemic (UNESCO, 2003). Consequently, these children, who are infected and affected by HIV/AIDS not only need physical and emotional support to continue living (UNESCO, 2003), but also require therapy to enable them live positively (Bacha, Pomeroy, & Gilbert, 1999; Carney & Cobia, 2003; Cobia, Carney, & Waggoner, 1998).

Purpose of the Article

The purpose of this article is to provide some insight into understanding the impact of HIV/AIDS on the lives of children infected with or affected by it. First, the etiology of the disease will be briefly described. Second, the impact of HIV/AIDS on children is discussed. Finally, the efficacy of employing counseling and play therapy techniques to assist children infected and affected by HIV/AIDS to cope with the effects of the disease will be explored.

Etiology of HIV/AIDS

HIV is an RNA-containing virus called a retrovirus (Howard, 2002). It is blood borne and sexually transmitted (Batterham et al., 2001). Retroviruses initially replicate in reverse (from RNA to DNA) because of unique enzymes called “reverse transcriptase” (Howard, 2002). Beginning in 1980s, the first cases of HIV infection were reported in the United States (Antoni, 2002; Coutinho, 2000; Fleming et al., 2000; Howard, 2002; Selwyn & Rivard, 2003). By the end of 2000, HIV/AIDS had infected an estimated 36.1 million people worldwide (Batterham et al., 2001). By 2001, there were an estimated 900,000 people in the United States of America living with HIV/AIDS (United Nations [U.N.], 2004). Additionally, there were approximately 15,000 deaths in the same year attributed to HIV/AIDS (U.N., 2004).

Sexual transmission is the most common method of HIV transmission. In addition, HIV-containing white blood cells and body fluids are passed on from one person to another (Howard, 2002; U.N., 2004). According to Howard (2002), this can occur in five different ways: (a) blood transfusion involving an HIV-positive donor and an HIV-negative recipient, (b) a particular blood-clotting factor isolated from the whole blood of an HIV-positive donor can be transfused into an HIV- negative recipient with hemophilia, (c) intravenous drug use, (d) maternal-fetal

transmission or "vertical transmission" results in pediatric AIDS, and (e) inadvertent transmission during an accident in a health care setting.

Impact of HIV/AIDS on Children

The impact of HIV/AIDS on children in Africa is well documented (Cross, 2001; Lindblade et al., 2003; Sarker, Neckermann, & Müller, 2005; Sayson & Meya, 2001; Sibanda et al., 2003; UNESCO, 2003; Young & Ansell, 2003). According to Mengel (2003), orphans are perhaps the most tragic long-term legacy of the HIV/AIDS pandemic. HIV-related ailments are the leading cause of death among infants and children (Sibanda et al., 2003). For instance, 5.6% of children in South Africa between 2 and 14 are infected with HIV (Sibanda et al., 2003). Children suffer either by becoming orphans following the death of their infected parents, being discriminated against, or by succumbing to the disease (Carney & Cobia, 2003; Rotheram-Borus, Weiss, Alber, & Lester, 2005; Sibanda et al., 2003). Moreover, the stigma attached to HIV/AIDS exacerbates the trauma, hampers the bereavement process, and exposes children to discrimination and victimization in their community and their extended family (Mengel, 2003).

The number of children orphaned by HIV/AIDS, especially in sub-Saharan Africa, is on the increase (Lindblade et al., 2003; Sarker, Neckermann, & Müller, 2005; Sibanda et al., 2003; UNESCO, 2003; Young & Ansell, 2003). According to UNESCO (2003), an estimated 13.2 million children have been orphaned by HIV/AIDS. By the end of 2003, 80% of the world's children orphaned by HIV/AIDS were living in sub-Saharan Africa (Sarker et al., 2005). In some regions of Africa, the percentage of children orphaned by HIV/AIDS is 2-13 times greater than the percentages of these children in developed nations (UNESCO, 2003). Sarker et al. (2005) noted that 41% of the children in their study were AIDS orphans. Additionally, an estimated one in every six households with children in the region is caring for orphans. A paragraph by Robinson (1999) appearing in Time Canada captures the magnitude of the HIV/AIDS situation in Africa:

> Esther Daiton begins her day early—vomiting bile into the toilet outside her Harare shack… Esther's father Daiton Malinga died of AIDS in April 1997. Her mother Nelia Nefitara died of AIDS in January 1998. Esther's eldest sister, Napiri, died in 1993. The next eldest sister, Martha died in 1995. Esther is the third sister. She discovered she was HIV-positive only after the birth of her daughter Emmaculate, who was chronically sick and died in 1998, age two. The fifth sister, Elina died of AIDS last year; the sixth, Maria, in May. Esther, 26, takes care of 11 other AIDS orphans in her family, from her brother James, 17, to her niece Manyara, 9, who is HIV-positive. Esther worries about who will take care of these children when she dies. (p.36)

The impacts of HIV/AIDS can be categorized into social, emotional, medical, physical, economic, and educational.

Impacts of HIV/AIDS

Social Impacts of HIV/AIDS

The number of children orphaned by HIV/AIDS is increasing (Carney & Cobia, 2003; Lindblade et al., 2003; Mengel, 2003; Sarker et al., 2005; UNESCO, 2003; Young & Ansell, 2003). According to Rotheram-Borus and colleagues (2005), at least 13 million children have been orphaned by the plague. Young and Ansell (2003) provided statistics from Lesotho and Malawi. In Lesotho, the number of AIDS orphans increased by 400% between 1994 and 1997 reaching a total of 73,000 by the close of the year 2001. In Malawi, the estimated number of orphans was 470,000 in 2001. According to Lindblade et al. (2003), the number of orphans due to HIV/AIDS in Kenya is estimated to be 1.5 million by 2005. By 2000, Uganda had 67,000 children infected with HIV and 1,100,000 children orphaned by HIV/AIDS (Brouwer, Lok, Wolffers, & Sebagalls, 2000). By the end of the decade, it is estimated that 44 million children will have lost at least one parent to HIV/AIDS in Africa (UNESCO, 2003).

With such figures, most households are now comprised of grandparents and orphans with the former, who are already vulnerable, becoming responsible for the care and upkeep of the latter (Brouwer et al., 2000; Sarker et al., 2005; Sibanda et al., 2003; Young & Ansell, 2003). Typically, the older members of the extended family are incapable of meeting financial and physical obligations of the increasing numbers of orphans under their care (UNESCO, 2003; Young & Ansell, 2003). Consequently, children are forced to move from one relative to another or even to foster care in order to survive (Young & Ansell, 2003).

Migration of children has been linked to the HIV/AIDS scourge (Young & Ansell, 2003). According to Young and Ansell (2003), young orphans in South Africa, a nation hard-hit by HIV/AIDS, migrate as a survival mechanism either to earn some money to assist in the living expenses of the extended family or to help their grandparents raise children whose parents have succumbed to HIV/AIDS. Still others move in order to receive assistance from the well-to-do members of the extended family. As a result of migration, some children have ended up becoming caregivers of their siblings and of themselves (Young & Ansell, 2003). At the same time, such migration has resulted in the dispersal of families and the break-up of family ties (Young & Ansell, 2003).

HIV/AIDS is viewed with shame (Bacha et al., 1999; Brink, 2003; Brouwer et al., 2000; Mengel, 2003; UNESCO, 2003). People suffering from the disease are often embarrassed to even say it aloud (Brink, 2003). These individuals experience stigma, isolation, and impoverishment (Bacha et al., 1999; Masmas, Jensen, Silva, Høj, Sandström, & Aaby, 2004; Mengel, 2003; UNESCO, 2003) and are ostracized by their communities (Bacha et al., 1999; Mengel, 2003; Robinson, 1999). According to UNESCO (2003), orphans are stripped of their possessions even by close relatives who are supposed to protect them. They are forced to live on the streets and are subjected to hostility, discrimination, and abuse.

Emotional Impacts of HIV/AIDS

Orphans infected and affected by HIV/AIDS experience emotional turmoil and cease receiving parental support even prior to the death of their parents or caregivers (Sayson & Meya, 2001; Young & Ansell, 2003). These children are profoundly affected by watching their parents

become sick, become incapacitated and unemployed, suffer stigmatization, and finally die (Rotheram-Borus et al., 2005; Sayson & Meya, 2001). They are also concerned about their family members living with HIV/AIDS (Carney & Cobia, 2003). In addition, they may experience HIV-related alienation once the HIV status of their parents become public (Brouwer et al., 2000; Rotheram-Borus et al., 2005). Following the death of their parents, the orphans undergo a period of grief and depression (Bacha et al., 1999; Mengel, 2003; Tsiwo-Chigubu, 2000) which usually remains unnoticed and for which they receive no counseling or rehabilitation (Tsiwo-Chigubu, 2000). They are now deprived of and long for physical contact in the form of hugs, kisses, and touch from their parents, yet, this contact is critical for their development (UNESCO, 2003). In her study, Mengel (2003) concluded that orphans have several emotional needs including longing for the deceased mother, preoccupation with the physical features of the deceased, anger, insecurity, preoccupation with death, and fear of death. In hard hit areas, not only do these orphans deal with the death of their parents, but also the deaths of their teachers and other significant adults and members of the community (Sayson & Meya, 2001).

Medical Impacts of HIV/AIDS

In the developed world, HIV/AIDS has been transformed from a disease that spelled out death to one that is controllable with antiretroviral drugs (Howard, 2002). On the other hand, the developing countries of Africa generally lack sufficient drugs to extend the lives of the countless numbers of people with HIV/AIDS (Brink, 2003; Uys, 2003) including the 40% of the children orphaned by and now living with HIV/AIDS (UNESCO, 2003). Others lack the money to buy the few available drugs (Brouwer et al., 2000). According to Brink (2003), only 1% of the estimated 4 million people in this region who desperately need drugs are receiving them. Yet, 27 million of the world's 40 million people with HIV live in sub-Saharan Africa (Brink, 2003). The problem is further compounded by the fact that more than 60% of new HIV infections occur in sub-Saharan Africa (Brink, 2003). Not only is lack of drugs or money a mitigating factor, but also millions of children with HIV/AIDS living in remote areas lack transportation to the few clinics that provide free antiretroviral drugs (Brink, 2003; Brouwer et al., 2000). Brink (2003) recorded a statement of a desperate HIV-positive mother and child, who have signed up for a home-based care in their village but cannot be reached by the people delivering the drugs, "Either I wait for help---I'm too weak to help myself---or I wait for the vultures" (p. 46).

The patient-to-doctor ratios in Central Africa are the lowest in the globe (Sibanda et al., 2003). Yet, an estimated 60% of the patients in hospitals suffer from HIV-related sicknesses (Sibanda et al., 2003). The scientific and medical personnel responsible for monitoring the disease and treating infected people are insufficient in relation to the number of people infected with the HIV virus (Uys, 2003). Due to the magnitude of the disease, the morale and health of the health workers is compromised resulting in an increased rate of absenteeism due to ill health or dampened spirits (Sibanda et al., 2003). Shortage of personnel and high workloads are other problems facing Africa (Uys, 2003).

Following the death of their parents, orphans not only lose the attention, care, and advice of their parents, but also lose access to resources such as land and shelter making them more vulnerable to poor health (Brouwer et al., 2000; Lindblade et al., 2003; Sarker et al., 2005).

Sibanda et al. (2003) posited that Africa is faced with the challenge of "diagnosing the condition, monitoring its impact, and contributing to treatment and management efforts" (p. 186).

Physical Impacts of HIV/AIDS

Orphans also suffer physical consequences following the death of their parents or caregivers. They lose the attention, care, and advice of their parents (Lindblade et al., 2003; Rotheram-Borus et al., 2005). Moreover, they are at greater risk for poor health and nutrition when compared to their counterparts with parents (Brouwer et al., 2000; Sarker et al., 2005). In most African communities, orphans have to survive on depleted resources following the arrival of new orphans into the family (Sayson & Meya, 2001). They must deal with issues arising from less financial resources such as lack of food, clothing, and shelter (Sayson & Meya, 2001).

Economic Impacts of HIV/AIDS

Orphans of HIV/AIDS often encounter economic hardships when their ailing parents or caregivers become too weak to sustain employment and thus lose their source of income (Sayson & Meya, 2001; UNESCO, 2003). Additionally, increased health care costs further deplete the already scarce financial resources (Sayson & Meya, 2001).

In the African setup, orphaned children are cared for by the extended family (Brink, 2003; Brouwer et al., 2000; Cross, 2001; Lindblade et al., 2003; Masmas et al., 2004; Sarker et al., 2005; Sayson & Meya, 2001). This system is on the verge of collapse as community resources are pushed to the limit because of the great number of children orphaned by the HIV/AIDS pandemic (Brink, 2003; Brouwer et al., 2000; Lindblade et al., 2003; Masmas et al., 2004). The staggering numbers of orphans needing care have resulted in economic hardships experienced by caregivers of children affected and infected by HIV/AIDS (Brouwer et al., 2000; Cross, 2001). With more children in the family, caregivers must provide tuition for the education of the orphans, yet they have their own children for whom they must also continue to provide (Cross, 2001). The weight of children being added on in marginal households without bringing with them any support can be more than enough to tip over the finances of households that were previously holding the line on income adequacy.

Educational Impacts of HIV/AIDS

Orphans usually have less access to education (Sarker et al., 2005). According to Sayson and Meya (2001), orphans often have to go to school with tattered clothes and without any school supplies. They may exhibit aggression, withdrawal, and classroom disruption (Bacha et al., 1999; Cobia et al., 1998). Consequently, they become embarrassed for being different from their peers. In addition, their minds are blocked by their emotional problems; thus, they may fail several classes (Brink, 2003). Left with no options, orphans finally drop out of school, and because they lack any skills and are frustrated, they end up on the streets (Sarker et al., 2005; UNESCO, 2003) or become criminals or prostitutes in order to survive (Sarker et al., 2005; Sayson & Meya, 2001). In fact, governments of African countries have been urged to provide educational opportunities for orphans as well as wipe out the discrimination experienced by these children (African Governments, 2005).

Counseling and Play Therapy as Coping Strategies

The plight of children infected and affected by HIV/AIDS is serious (Carney & Cobia, 2003). According to UNESCO (2003), "This is an emergency! Action needs to be taken now, as young children (0-8 years) are most vulnerable to the disease, malnutrition, and unmet psychosocial needs critical for their socialization and survival" (p. 7). Affected and infected children need opportunities to share their emotions with trained counselors and therapists following pre- and post-diagnostic testing (Uys, 2003). In Africa, this is a challenge to accomplish because patients do not return for their results, work pressures, and staff shortage (Uys, 2003). In addition, the confirmation of an HIV diagnosis may result in family rejection (Bacha et al., 1999) or disgrace since the disease is associated with promiscuity (Uys, 2003).

School counselors have the capacity to improve the lives of children and adolescents affected or infected with HIV/AIDS by providing counseling opportunities (Carney & Cobia, 2003). The first step for counselors is to assess the needs of the child with HIV disease pertaining to how and at what age the disease was acquired and the current developmental stage of the child (Carney & Cobia, 2003; Cobia et al., 1998).

It is imperative that counselors are knowledgeable about HIV/AIDS and its psychological impact so they are able to provide the necessary training in prevention and assessment (Carney & Cobia, 2003; Cobia et al., 1998). They must know about the progression of the disease, prevention, testing, and assessment (Carney & Cobia, 2003). In addition, it is crucial to ensure the child understands his or her condition and possesses knowledge on the disease and its impact (Cobia et al., 1998). Counselors must consider issues including confidentiality and how to assist children/adolescents in disclosing their status to and sharing their emotions with parents (Cobia et al., 1998). These emotions include anger, shock, disappointment, sadness, confusion, anxiety, and fear of death, (Cobia et al., 1998). School counselors have the potential of intervening with these groups of children and adolescents to decrease their anxiety (Cobia et al., 1998). The children and adolescents will have the opportunity to express their fears and concerns either in individual counseling sessions or during group therapy sessions (Cobia et al., 1998). To be effective, counselors must address their beliefs about the disease including their concerns regarding transmission of the disease, grief, social stigma, and their comfort levels in interacting with people with HIV/AIDS (Carney & Cobia, 2003).

Despite the scarce literature on play therapy and its implications for children with HIV/AIDS, it has been reported to be effective with younger children with HIV/AIDS (Bacha et al., 1999; Cobia et al., 1998; Nolting & Porretta, 1992). Children with HIV/AIDS need to be taught how to play and interact with their peers so they may realize their potentials and enhance positive feelings about themselves either in individual or group sessions (Nolting & Porretta, 1992). It enables the child to express emotions related to his/her fear of death, vulnerability, changes in physical health, and concerns about family and peer acceptance (Cobia et al., 1998). Play therapy can be crucial in building self-esteem, developing problem-solving skills, and enhancing conflict resolution (Cobia et al., 1998).

Bacha and colleagues (1999) conducted a pilot project that used a psycho-educational group intervention for children with HIV/AIDS. They combined play therapy techniques with information on HIV/AIDS in order for the children to benefit cognitively and emotionally. The study aimed at increasing the children's self-esteem, their sense of control of their lives, and to decrease their sense of hopelessness and depression. Six children participated in the study. The

findings indicated the positive outcomes of using play therapy techniques for children infected with HIV/AIDS including a reduction in their feelings of loneliness, a deeper understanding of the disease, and a more positive outlook of their daily lives.

Play therapy techniques are being used in Uganda for children with mental and physical needs including those with HIV/AIDS (Alliance for African Assistance, n.d.). The program is utilized as a physical and mental remedy for children between the ages of 5-16.

Conclusion

HIV/AIDS has had and continues to have a profound impact on the social, emotional, and medical aspects of life. Its impact on the lives of children infected with and affected by the virus is evident. It has left many communities, especially in Africa, completely shattered. HIV/AIDS has mercilessly taken the lives of many parents leaving behind orphaned children. Some of these children are ailing; yet, they have no caretakers. The epidemic has left many families replete of financial resources by virtue of the expensive medications needed to prolong the lives of loved ones. It has left many families and individuals feeling socially isolated and discriminated against because of the negative attitudes attributed to HIV/AIDS. Sayson and Meya (2001) summed up the situation accurately,

> The effects of the epidemic especially in Africa are starkly obvious – follow the banana plantations going fallow, the houses closed or abandoned, the funeral processions on the roads, and the recent graves near homes where grandparents care for children whose parents have died. (p. 4)

There is great need, therefore, to direct more effort to finding a cure that will end the epidemic and save the many lives that are being lost. Counseling and play therapy has been found to be beneficial to the many children suffering from the effects of the pandemic.

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