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techniques prior to commencement. Some obtrusive methods appeared difficult and needed to be demystified for implementation to suit the group environment.

The objective of identifying and tailoring psychological skills management was given spontaneous recognition in meditation. Our specific purpose was to attain greater mental strength, concentration, stability and equipoise in day-to-day practical life (Mumukshananda, 2002). Members conceded that uncluttering their minds was pivotal to emotional health, which could maximise self-care and management.

A meditation instructor introduced us to the most general techniques, which included the following five steps:

Step 1 – Preparation and posture
Step 2 – Breathing
Step 3 – Centring
Step 4 – Visualisation and imagery
Step 5 – The word.

On numerous occasions we novices transgressed these steps, but the teacher was able to skilfully tailor them to meet our purposes and simultaneously assuage our anxiety. We assiduously practised daily at home; however, as protégés we continued to rely on the periodic assistance of our teacher. In retrospect, we still find it an illuminating daily experience as we try incrementally to develop some degree of proficiency.

Music/dance/movement therapy and guided imagery

Dance movement therapy is a psychotherapeutic use of movement and dance through which a person can engage creatively in a process to further their emotional, cognitive, physical and social integration (ADMT, n.d.). This physical activity was used to complement other exercises undertaken in the session and also to emphasise the patterns of feeling and thinking that invariably promote personal growth. Music, chosen by members as an accompaniment, was appropriate and effective. The benefits included increasing self-awareness; coherence between thoughts, feelings and action; articulating and managing overwhelming feeling/thoughts; locating inner resources through contained creative play; checking the impact of self on others; examining inner and outer realities; and increasing social interaction to develop a trusting relationship.

The group experienced this innovative therapeutic form as “flying out of my centre” and also reported that it was exhausting yet exhilarating.

Guided imagery and music is a technique in which the act of listening to music is combined with a relaxed state of the body in order to evoke imagery for the purpose of self-actualisation (www.onwellness.info/0...music.../music-therapy-ageless). The combination is conducive to maximising the inner journey which promotes healing. This method, based on humanistic therapy, is greatly influenced by Maslow and Jung. On completion of these exercises, members noted that not only were they highly active, but served to relieve inner stress and tension. One member noted that “singing aloud and out of tune” served to revitalise her, despite her arduous and tiring day. The one member who was pregnant at that time remarked that just exposing her to music and dance therapies served to reconcile inner feelings of frustration and exhaustion, and helped to somehow navigate her towards her spiritual being.

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Formalised story telling

The use of a journal and timeline validated for members their thoughts and feelings at pivotal stages in their lives (Miller, 1999). They also engaged in "life-telling" which also provided a rich narrative about themselves which was consistent with their present feeling and thoughts. They maintained interactive dialogue about sometimes sensitive issues pertaining to their past, which undoubtedly warranted further therapeutic intervention. One member in particular was duly referred for further individual therapy on the recommendation of the leader. The wealth of information generated by this exercise also promoted group cohesion and optimised our group experience.

Muller (2006) advocates a "storying culture". He notes if there is a richness of stories available in our memory, it serves as a "bed" on which you can lie. He notes that the sharing of simple stories can be powerful instruments of care. Comments from members about the therapeutic effect of this exercise proved gratifying and progressively manoeuvred us toward healing. We constantly asked ourselves "What is this encounter supposed to teach me?"

Spirituality and the resilience of the human spirit

Kubler-Ross (1995:80) warns that we have to make the transition from an age of science/technology and materialism into a new age of genuine and authentic spirituality. She adds that a distinction must be made between religiosity and spirituality – which is an awareness that there exists something far greater than we are, something created by the universe, that we are an authentic and vital component of it, and that we do add to its evolution.

Kasiram, Partab, Dano and Greunen (2003) maintain that the challenge in truly accessing spirituality is central to care-giving: valuing service to people and appreciating the unifying rather than the dividing principles of spirituality will effectively allow spiritual access.

This theme called into direct question the difference between religion and spirituality, and whether contemplating each separately confused rather than clarified issues. Feeling impelled to understand our own religious beliefs and how they informed our identities was at the core to our comprehension of this incredibly lengthy discussion. Time constraints prevented the group from exploring more nuanced and textured narratives. Members recounted and reflected on the effect religion had in their lives and maintained that ritual provided an anchor and was an indisputable fount of their living. The spiritual oasis, we agreed, is what one as an individual contributes to the universe and returns to daily to draws sustenance from, which gives one the impetus to continue. One member declared that she was "not a Christian, but a church goer!" Yet another commented on present decorum and how this contributed to her patients assuming that she was very pious because she wore a rosary to work. Critiquing these areas was both agonising and elevating, and demonstrated the extreme difficulty of confronting this contentious issue. Although some statements had the effect of annoying and agitating some members, this was ultimately not harmful to group cohesion and co-operation. Engaging in the exercise assisted in blurring boundaries and highlighting our own areas of discomfort. One captivating comment made by a member that elicited spontaneous discussion was that "we need to rejoice in the fact that we are not HIV positive". This statement encapsulated the sentiment shared by the group. They eventually compromised by saying that "life has to be celebrated".

Death and dying

Research (Ferreira *et al.*, 2000; Lehmann & Zulu, 2005; Smit, 2005; Van Dyk, 2007) has established a clear connection between HIV/AIDS caregiver burnout and bereavement

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overload. Students also encountered feelings of despair and doom when working with issues of death.

The demands on the group of working with issues of death can be both challenging and painful. As Getzel and Mahony (1993) point out, caregivers have to bear witness to tragic loss. She adds that the need for support, recognition and finding an outlet for cumulative grief responses is a *sine qua non* for workers serving PWAs.

The students had been exposed to 12 lectures in their final year on Bereavement Counselling on the following themes: phases of grief, tasks of mourning, art of conveying condolence, principles of grief counselling, AIDS and grief, children and grief, cross-cultural perspectives on death, attitudes towards pain, dying and death, grief reactions and practices, social status of the deceased, social status of the bereaved, and rituals of death, funerals and mourning.

This module, taught by the author, provided students with adequate knowledge and skill, but left little opportunity to broaden and deepen their understanding of their own feelings about and/or fear of death. What was identified as crucial in the discussions was that one needs to assess the following:

- What is the meaning of MY life?
- What do I want from it?
- How can I create the life I desire?
- Am I fully functional at present?

Death and living are integral to the human condition. Undoubtedly culture and religion impact on our understanding of death. When confronted with death, the preciousness of life becomes glaringly obvious. Human service professionals not only encounter their clients' feelings about death, but they themselves are acutely aware of their own mortality. Kubler-Ross and Kessler (2001) note that in the school of life, dealing loss is a major component of the curriculum. However, this prophetic phase is sometimes difficult to deconstruct and demands validation and positive connotation of what constitutes one's life. In the oscillation of life, can we determine a definite beginning and end?

Time out for personal reflection, as recommended by Corey and Corey (1997), was used to initiate the discussion on death, dying and living. Central to this discussion were pertinent issues which included the following:

- Identifying with the fears that one experiences when one thinks about one's own death;
- Listing specific things group members are not doing presently that they would like to do;
- Identifying how the fact that they will die gives meaning to their present life;
- In what ways do group members think their present fears of death and dying will affect the choices they make in the future;
- Writing a brief description of what they might do if they had only six months to live.

Many of the discussions evolved from total denial and accusations of being "too morbid" to reminiscing and eventually conceding that members need to create their own comfort zone on these questions, since they highlight the implications of their own demise.

Kubler-Ross, a pioneer who wrote extensively on the stages of dying when working with PWAs in her book *AIDS: The Ultimate Challenge* (1993), emphasises the five stages of dying, which members were able to identify with in their own work with PWAs. The intersection of

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the personal and professional was easily demonstrable upon completion of these sessions for the students.

The therapeutic value of humour

> Seriousness is equated with responsibility, when in fact, I think we could be much more responsible if we had more joy and laughter in our lives. (Deepak Chopra)

Human service practitioners, and especially those working with persons with life-threatening diseases, are confronted with the occupational hazard of severe stress in their professional lives. Their compassion is supposed to be unconditional and unrelenting. Is it therefore insensitive and unethical for them to use humour in their professional lives, or can this be construed as radical healthcare? Of importance is a guiding ethical principle, which should always be adhered to, that at no stage should client confidentiality and professionalism be compromised when practitioners are engaging in jocular activity. At no time should a caregiver ridicule, belittle or become sarcastic (Ball, n.d.).

Parrish and Quinn (1999) maintain that caregivers who successfully manage the unique demands of providing care use humour to release tension and anxiety. In a work environment involving pain and suffering, humour can serve to build purposeful relationship with clients.

In her lectures the author advocates incorporating jocular activity. The results have proven to be not only successful, but have ensured a responsive and attentive class. The levity contained within even a potentially morbid module such as Bereavement Counselling has demonstrated that students were excited and enthusiastic about the lecture, without devaluing the seriousness of the content. Moreover, the author's levity incited and stimulated the students' sense of humour, which could be considered an adjunct to the author's present teaching methodology.

Laughter is a self-refilling medicine, for the more you laugh, the more you laugh (Kubler-Ross & Kessler, 2001:161).

Craig (2001:55) summarises the psychological and physiological effects of laughter.

- Psychological effects include: buffers and moderates the physical effects of stress, improves mood in coping with sadness and loss, adjunct to psychotherapy, reduces anxiety, improves performance and teamwork, coping with terminal illness, hospitalisation and major medical procedures.
- Physiological effects include: longevity, reduces pain and improves pain threshold, enhances relaxation response, reduces stress hormones (e.g. cortisol), improves immunity, reduces stress hormones and buffers against the immunosuppressive effects of stress, improves blood and lymph flow, increases oxygenation, lowers blood pressure and exercises muscles.

Group members attempted to relate our narratives on humour and our relationship with laughter, quoting anecdotal incidents that evoked laughter. Dominelli (2004) correctly asserts that "new" narratives allow for new possibilities to open up. Members confidently recounted these incidents without fear of reprisal from others in the group. Parrish and Quinn also note that storytelling and human nature conspire beautifully to produce laughter and humour naturally in a group environment. In order to facilitate discussion, members answered a brief questionnaire, which contained the following questions:

- What is your definition of humour?
- Specify who in your life tickles your fancy?

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- Do you think you are funny/witty?
- What in life will you not see humour in?
- Do you remember a funny joke? If so, how often and when will you use it?
- Do you think that you use humour to de-personalise issues?
- Do you always want a captivate audience to tell a joke?
- Do you use humour as a defensive mechanism?

After much discussion, it was deemed imperative to incorporate humour within group members' arsenal of skills and to also broaden their repertoire. It was prescribed that that those who did not possess a humoristic side should immediately undergo "Humour Replacement Therapy".

The ABCs of developing humour by Parrish and Quinn (1999) served as perfect steps to follow. The use of humour is not only pleasure-inducing, but could alleviate stress and elevate the spirit to soaring heights, even if this provides only temporary relief on our stressful days.

Group work: an appropriate method of addressing compassion fatigue

Dominelli (2004) asserts that groups have been used to promote self-determination and confidence. Support groups for professionals working with PWAs have been recognised as a necessary resource (Grossman & Silverstein, 1993). The benefit of choosing this method is further endorsed by Greif and Ephross (1997:2), who affirm that participation will lead towards growth, healing, expanding and enhancing social functioning, and learning the expression of democratic citizenship, the practice of self-determination, mutual aid and mutual support.

Students were convinced that the power of participation and the process of sharing would generate a cathartic experience, instil hope, create mutual support, afford discussion on emotional issues, and eventually assist in the development of their own self-care plan. Strug and Podell (2002) also note that emotional support in a group environment adds to the healing presence of group members.

Self-reflection comprised a substantial component of the group process and the benefits were encouraging. Gibson *et al.* (2002) emphasise two specific advantages for care-workers:

- It provides a means of working through some of the strong emotions that are evoked in care work in order to prevent emotional distress and the long-term problems associated with burnout;
- It prevents care-workers from acting impulsively or unhelpfully with clients.

The synergistic properties of group work would dovetail students' practice and learning, and propel them to develop a better understanding of themselves as social workers. Steinberg (2002) alludes to the exchanging of strengths for personal and interpersonal good. She lists three areas of connections:

- Between people, theory and practice;
- Between need and group purpose;
- Between the psyche of needing help and the psyche of being helpful.

Vertical connections direct members to recognise both the right and capacity of people to have a say over their own affairs, which is one of the ways of engage in mutual aid.

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Horizontal connections provide the correlation between the here and now. By connecting the needs we see with possibilities for group purpose, we develop vision. By connecting intent with professional action, we translate vision into work. Catalysing mutual aid is fundamental to social work and further demonstrates that people have the right to shape their own destinies and possess the inherent capacity to contribute to their own development.

It was agreed that the aim of the sessions would be to constructively develop a self-care plan that would suit members' individual needs, which could ultimately be used as a resource in the future. It was also deemed appropriate to use the group environment to address a fusillade of questions around caring for PWAs. Garside (1993) notes that groups permit the sharing of difficult emotional realities when working with PWAs and their families.

Students were initially requested by the author to explore the following questions individually in preparation for their pre-group interviews:

- Why do you think that the group is best for addressing your concerns?
- What do you view as the purpose of the group?
- What do you specifically envisage getting from the group?
- Are you ready to look critically at your life and undertake an authentic audit of yourself?
- Are you ready to confront unpleasant/awkward issues in your life?
- What are the specific personal issues that you will like to discuss?
- How will this group experience assist in achieving your goal?
- How will this group address planning for self-care management?
- How do you see these sessions contributing as an investment to your future as a social worker?

A life history, seven-page questionnaire (adapted from Johnson, 1997) was also utilised as a point of departure for members, who completed this thought-provoking exercise over two days. Commenting on their experiences they recalled how "agonising, yet necessary" the exercise was and maintained that the comprehensiveness ensured a retrospective cursory understanding of their past. Moreover, they were able to question what "exhausts and what exhilarates" in their lives. The authentic audit of themselves created a scenario of individually acknowledging areas of competence and development. One member maintained that some toxic issues which she often chose to sublimate virtually "glared back at her" for confrontation. The notion of confronting realities is paramount in self-care management.

Post-session reflections and learning curves

The author felt it prudent to capitalise on students' request for an evaluative tool, because they demonstrated authentic interest in exploring/reflecting on their experiences, which ultimately led to introspection and self-exploration. I further felt compelled and enthused by their identifying with the awesome power of a group experience, where they witnessed theory articulating into practice. The false dichotomy often created by implementing theory into practice was challenged and these two dimensions successfully cohered and harmonised into a meaningful experience for both the leader and group members. Kaslow (2003) notes that facilitating groups is a challenging, humbling and amazing experience. My own experience was indeed not only immensely gratifying and promoted clinical expertise, but indicated and informed necessary changes to my curriculum.

Breton (2002) validates this feeling by noting that mutual-aid group involve not only intra-group solidarity and its healing power, but inter- and extra-group solidarity and its liberating

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power. This mutually beneficial exercise, although exhausting, contributed significantly to the author's professional growth, and harnessed my existing facilitation skills as a group leader and lecturer. The sessions also made clear the inextricable link between self-actualisation and one's own professional development. The self-reflection exercises provided a distinct and cognitive lens from the students' developmental areas and motivated them to move unequivocally towards personal and professional growth. These creative exercises assisted in pushing boundaries, delving into our own past, connecting with how the past informs our present identities, and finally capacitating members and the leader, who in retrospect had to extend her own theoretical comfort zones. In hindsight I understand that not only has this opportunity contributed to my own professional development as a group worker, but it also indicated clearly that professional development is a lifelong process. The preparatory work, which was extensive and rigorous, often presented an avalanche of information that needed to be meticulously chosen to fit group purpose and goal. This was also a learning experience.

Another residual benefit of facilitating this group was the indication of the necessity of including spontaneity in our practice. This forces the student to extend beyond informed conventional wisdom. The eclectic responses from members, who were extremely committed to adhering to group goals, ensured group growth and progression. My incremental theoretical knowledge came to fruition, was tested, challenged, deconstructed and eventually reconstructed.

Moreover, the power relations dynamic pervasive in group work became a learning mechanism for both the members and the leader, who had to be constantly cognisant of its presence. Dominelli (2004:253) makes the point that it is time to reorient power relations within the relationship. In addition, the complexities and ambiguities that underlie our own lives were acknowledged and honestly discussed, which clearly fostered a fruitful and challenging learning experience.

Challenging assumptions and being a critically reflexive practitioner do require their own mental gymnastics, but they did provide the foundation for members to actively question their own existence, which was initially identified as a group goal. A distinguishing benefit of facilitating a group of this nature was that, as the group generated its own creativity it directed me towards exploring my own dormant creativity. Without question the self-imposed solitude engaged in after reading through their evaluations navigated my own professional development and either affirmed or begged change. My passion for group work was nourished after this experience, despite my one very sophisticated error that required more thorough exploration, namely that of spirituality.

Members reported that they felt that the time limit on this theme did not afford them sufficient opportunity for the in-depth discussion they initially envisaged. It was patently obvious that I need to be more flexible and spontaneous about abandoning highly formulated plans for a session and employ alternative techniques that are more conducive to group growth. I remain convinced that conventional wisdom needs to be challenged openly, respectfully and purposively. Although each theme appeared extremely loaded, it served both as illuminating and exploratory. Brook and Davis (1985) point out that we should not expect clients to bare their deepest thoughts and frustrations, while we sympathise from within our sterile bubbles.

CONCLUSION

Malekoff (2002) rightfully notes that what passes as group work is nothing more than curriculum-driven pseudo-group work, which stamps out spontaneity and creativity. My own experience of facilitating this group with members from the class helped not only to demystify this modality of social work to them, but indeed suggested that conventional and mediocre

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methodologies can be challenged and injected with innovation to sustain interest and make group work an exhilarating, exciting and enduring method of choice. The anti-oppressive lens projected within the group reinforced the notion of reciprocity that was felt both by the leader and members (Dominelli, 2004).

Fox (2002) reflects that in caring for the carers we are not only ensuring optimal care for the PWAs, but that – for the sake of our own survival – we should also be mindful that this is an interdependent relationship. This experience demonstrated that groups can provide a safe environment to expose emotional despondency, compassion fatigue, create an empathetic milieu, ameliorate student burnout and vicarious trauma, alleviate stress, and promote healing. Moreover, it is asserted that self-care should not be relegated to a low priority and regarded as negligible in the lives of healthcare professionals, as this ultimately leads to vicarious trauma. The feeling was that the group environment facilitated discussions on all themes, with the exception of spirituality, which the leader acknowledges is a topic for further exploration. Perhaps it could be included at a more elementary level.

Getzel and Mahony (1993) write that the lessons learnt when working with PWAs are strange and wonderful, and that the experience is worth every minute.

It is strongly suggested that support groups for students working with PWAs become a mandatory resource to ensure optimal service delivery to this client population. This pragmatic, powerful and salutary effect has been epitomised by responses from group members, who have undoubtedly given their stamp of approval to group work as a responsive manner of effectively facilitating individual change and employing effective strategies to manage self-care. They conclusively answered the question "Who cares for the care-giver?" by indicating that this is their own responsibility.

Goldenberg and Goldenberg in Khoza (2006) advise: "Face the fact that you must grow until you die. Develop a sense of the benign absurdity of life – yours and those around you."

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