

A MODEL OF COGNITIVE BEHAVIOURAL THERAPY FOR HIV-POSITIVE

WOMEN TO ASSIST THEM IN DEALING WITH STIGMA

by

JAN TSHABALALA

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DEDICATION

This dissertation is dedicated to
HIV-positive people, from whom we learn so much on a daily basis.

ABSTRACT

In this study, a model of cognitive behavioural therapy (CBT) was developed, implemented and assessed. The aim of this model is to assist HIV-positive women in dealing with internalised and enacted stigma. Since much of the research about therapies developed to deal with HIV-related stigma so far has been done within a western frame of reference, in the current study a model was developed to suit the local South African situation.

Women were specifically targeted as they are more vulnerable to HIV/AIDS and are disproportionately affected by the epidemic. Because of culturally determined gender roles, women are not always in a position to take control of their sexual health. Furthermore, because of the negative experiences of HIV diagnosis, the stigma has a negative impact on women's behaviour. As a result, there is a need for a therapeutic model to assist HIV-positive women in changing the experience of internalised stigma and discrimination.

A CBT approach was used in therapy to challenge the women's dysfunctional beliefs, to change their automatic thoughts and to promote more realistic adaptive patterns of thinking. All of these aimed to assist them in dealing with stigma. Eight therapy sessions (one a week for eight weeks) were planned for each of the women.

This research was conducted in two phases. In Phase 1, data was gathered about the experiences of HIV-positive women to gain an understanding of their experiences of HIV-related stigma and discrimination. Various sources of information were used to identify not only the relevant themes contributing to the individual's experience of internalised stigma, but also possible ways to change them. These sources included a study of the available literature, the researcher's own experience and focus group discussions with other psychologists in practice, and interviews with five HIV-positive women (in the form of case studies). Five women living with HIV/AIDS, who were experiencing difficulties in dealing with stigma, were recruited at Witbank Hospital, where they were interviewed and asked to complete five psychometric instruments. The researcher scrutinised the data gained from the psychometric scales to assess the validity of the instruments to identifying the feelings of the participants the researcher observed in the interviews. Rubin and Rubin's (1995) method was used to analyse the data. The findings that emerged from Phase 1 were used to identify common themes to be addressed in the intervention, for example feelings of powerlessness, feelings of guilt, behavioural implications of stigma, the experience of the reaction of others and uncertainty about the future. These themes were used as guidelines and were adapted according to the specific needs of each of the women seen in therapy so as to address negative feelings and behaviour.

Phase 2 focused on the implementation and evaluation of the cognitive behavioural model. A purposive sampling technique was used for this study. The model was tried out with ten HIV-positive women who served as the experimental group. A quasi-experimental design was used, involving a pre-and post-test and a control group consisting of ten other women identified at the same hospital. The scores that the experimental group and the control group obtained before the intervention were compared to verify that the two groups were comparable prior to the intervention. Post-test scores were compared to investigate differences between the groups after the intervention. The process notes of the therapy sessions were analysed by means of qualitative analysis to understand the reactions of the women in therapy. This contributed to the researcher's understanding of the appropriateness and effectiveness of various therapeutic techniques used with the experimental group.

Findings of this research indicate that, when compared to the control group, the experimental group not only experienced less depression, internalised stigma and negative coping, but also higher levels of self-esteem and positive coping after having participated in eight therapy sessions. The study further revealed that being HIV positive and trying to cope with stigma and discrimination involve diverse experiences for women, although there are common themes for all participants. It was recommended that the intervention be altered in future use in the following ways: Those techniques that were found to be more effective with the majority of women (positive cognitive reframing, teaching of coping strategies, homework assignments, decatastrophising and assertiveness training) could probably be used with success in similar conditions. Only the techniques that worked well should be used, and care should be taken not to use too many techniques. Each client should be given the time to question the evidence for her automatic thoughts and to draw her own conclusions about her situation, feelings or thoughts and to grasp the cognitive strategies, rather than to bombard her with many different techniques. The therapist should also relate more to the individual client and adapt the model to her context, rather than to implement the model rigorously.



KEY TERMS

Women living with HIV

Cognitive behavioural therapy (CBT)

HIV/AIDS-related stigma and discrimination

Psychometric scales

Coping with HIV/AIDS

Stigma

CBT model dealing with stigma

Mixed methods research

Case studies

Quasi-experimental design

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CHAPTER 1

INTRODUCTION

1.1 ORIENTATION TO THE STUDY

The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2007) states that at the end of 2007, an estimated 33, 2 million people around the world were living with the human immunodeficiency virus (HIV). This figure includes the 2, 5 million people who acquired HIV during the course of 2007. The epidemic also claimed an estimated 2, 1 million lives in 2007, of which 76% occurred in Sub-Saharan Africa. Sub-Saharan Africa remains the most affected region and is home to about 22, 5 million of the total number of people living with HIV worldwide. South Africa is the country with the largest number of HIV infections in the world with AIDS remaining the leading cause of death.

In regions where the epidemic has been raging for years, more women are the worst affected and infected than men, and in countries where the epidemic is just beginning, new infections among women outnumber those among men (Bell, 2002). The majority of people living with HIV in Sub-Saharan Africa (61%) are among women (UNAIDS, 2007). Women in Africa are being infected at an earlier age than men and the gap in HIV prevalence between men and women continues to grow. There are, on average, 13 HIV-positive women for every 10 HIV-positive men. The difference in HIV infection levels between women and men is even more pronounced among young people aged 15 to 24. Driven by poverty and the desire for a better life, many women and girls find themselves using sex as a commodity in exchange for goods, services, money, accommodation or other basic necessities - often with older men. Social inequalities, poverty and migrant labour provide fertile ground for exploitative transactional and intergenerational sex in Southern Africa (UNAIDS, 2004).

Part of the reason for the rapid increase in female HIV infection is that it is physically easier for the women to contract HIV through intercourse than it is for men to get it from women (Ross, 2004).

Fredriksson and Kanabus (2004) express the view that HIV-positive women are treated very differently from men in many developing countries. Men are very likely to be "excused" for the behaviour that resulted in their infection, whereas women are not. In some African countries, women whose husbands died of acquired immunodeficiency syndrome (AIDS) or AIDS-related infections have been blamed for their husband's deaths.

AIDS currently overtaxes social systems. The rising death rate is immobilising the economies, education and health services of many countries; Africa is currently facing an orphan crisis unprecedented in human memory;

grandmothers are denied a peaceful old age by having to bury their children and care for their grandchildren; stigma and prejudice remain rife, making HIV infection and AIDS an unspeakable disease not to be named or talked about; and the rights of women and children are widely disregarded – leaving them disempowered and unable to protect themselves from HIV/AIDS (Van Dyk, 2005).

HIV/AIDS impedes the health and educational development that enables poor people (especially children) to escape poverty (UNAIDS, 2004). In health care systems in many countries are stretched beyond their limits as they have to deal not only with growing numbers of AIDS patients, but also with the loss of health personnel. Women in general and girls in particular are more vulnerable to HIV/AIDS and are disproportionately affected by the epidemic. Females also bear the greatest burden of care for family members who are infected (International Community of Women Living with HIV/AIDS/ICW, 2003). Some families often remove girls from school to care for sick relatives or assume family responsibilities (Palitza, 2005), thereby jeopardising recent gains in female health, nutrition and education (Canadian International Development Agency/CIDA, 2004; Community Workers Co-operative/CWC, 2003). In education, teachers and students are dying or leaving school, which reduces both the quality and efficiency of educational systems. This trend has an especially detrimental impact on the girls' own development and leaves them more vulnerable to the epidemic. Girls who have not completed their schooling are less likely to obtain the earning power to increase their economic independence and are more likely to resort to transactional sex in order to survive. Reduced education for women also impedes national development (CWC, 2003).

Women and girls in the developing world are increasingly becoming HIV/AIDS' main victims and current safe-sex prevention strategies are of little use to the millions who do not have the power to say 'no' to sex or to insist on condom use (Centers for Disease Control and Prevention/CDC, 2001; ICW, 2004; Lawrence, Brasfield, Jefferson, Alleyne, O'Bannon III & Shirley, 1995; Ross, 2004). It is under such circumstances that researchers can make use of the lessons learned in developed countries, but the African HIV/AIDS epidemic should be approached from an African perspective. A cultural norm such as the community's acceptance of polygamy encourages males to have multiple sexual partners, which inevitably contributes to the rising rates of HIV infection and place South African women at risk for contracting HIV (Abdool Karim, 2005).

The inequality women face - from poverty and stunted education, to rape and denial of women's inheritance and property rights - is a major obstacle to victory over the virus (Ross, 2004).

Married women in some African countries are in greater danger of contracting HIV than unmarried ones, because women often marry men who are much older

than themselves – for the sake of financial security – and these men are sexually more experienced and therefore more exposed to HIV. Women's position in relationships also exposes them more to HIV (Ross, 2004), because their status is inferior to that of men. They have very little control over their sexual lives and over ways of preventing sexually transmitted infections, which makes it much easier for them to contract HIV.

According to the International Center for Research on Women/ICRW (2002a), the HIV/AIDS epidemic has from the beginning been accompanied by an epidemic of fear, ignorance, blame, isolation, uncertainty, misperception and denial of HIV/AIDS (Awusabo-Asare, 2000; LeBlanc, London & Aneshensel, 2000; Whelan, 2002). This leads to the stigmatisation of and discrimination against both the people living with HIV/AIDS and their family members (De Bruyn, 1999; Wardlaw, 2000).

The stigma related to HIV is a major barrier in addressing the HIV/AIDS pandemic because it has a negative effect on all aspects of prevention, diagnosis, treatment and care (Deacon, Stephney & Prosalendis, 2005; Bond, Chase & Aggleton, 2002). The stigma has an impact on the behaviour of HIV-infected people and the choices they make. Earlier in the epidemic it was found that in some African communities people were more fearful of the social consequences of AIDS than of the disease itself (Lie & Biswalo, 1994). The fear of HIV/AIDS is still prevalent in a country like South Africa. Parker and Aggleton (2003) agree that since HIV/AIDS first appeared in the 1980s, it has been associated with fear, stigmatisation and discrimination.

During the years discrimination has become more subtle and less explicit. In the past, for example, people may have been fired outright when it was discovered that they were HIV positive. Today they may be laid off for "other reasons", or they may be harassed and pressured to the point that they leave their employment or go on early pension (De Bruyn, 1999). Fear of being identified at work and of losing their employment even prevents some people from taking HIV-related medications (Hubley, 2002; ICRW, 2002a; 2002b).

1.2 MOTIVATION FOR THE STUDY

An HIV diagnosis is a serious life crisis that requires considerable coping resources. When receiving an HIV diagnosis, people have to deal with issues such as death, HIV-related symptoms, change in life expectancy, change in body image, disclosure, mistrust in their relationships, stigma, possible social isolation and rejection (Hudson, Lee, Miramontes & Portillo, 2001).

Various aspects can prevent women from getting the treatment that they may need such as the stigma attached to HIV/AIDS, inaccessibility of clinics, lack of money and too many other responsibilities (CIDA, 2004). Negative attitudes of

health workers towards women presenting with HIV/AIDS may be another measure that acts as a deterrent to their seeking treatment (Hubley, 2002; ICRW, 2002a; 2002b) or even contraceptives.

The dominance of male needs and the denial of female needs impede open discussion between the sexes and limit people's chances of mutually satisfying, respectful and safe forms of sexual behaviour. To curb HIV transmission, both partners should be able to express their worries about infection and use protective measures such as condoms. This should follow out of respect and affection, rather than to be a sign of mistrust (CIDA, 2004).

Combating the stigma and discrimination suffered by people who are affected by HIV/AIDS is as important as developing medical cures to prevent and control the global epidemic, and assisting HIV-positive people to deal with stigmatising attitudes (Fredriksson & Kanabus, 2004).

Because stigma has an impact on prevention and care, it is important to address it (Siyam'kela, 2004). The magnitude of stigma has had a seriously detrimental effect on HIV/AIDS testing (CDC, 2001).

The above observations are particularly true for the people living with HIV/AIDS whom the researcher observed while working at the Witbank Hospital. As a result of the various phases in a person's adaptation to the disease, a clinical psychologist who is a member of a multi-disciplinary team would assist the patient to comply with his/her treatment and come to terms with this chronic illness. Because of the negative experiences following an HIV diagnosis such as being rejected by significant people, the stigma has a negative impact on the behaviour of HIV-positive people and the choices they make. As a result, they need to understand their experiences in order to deal with stigma. An intervention model that was developed as part of the current study assisted HIV-positive women in coping with their own disease.

There is insufficient documented research that investigates the nature and level of stigma that HIV-positive people experience (Visser & Makin, 2004). The majority of the research conducted in this field has been carried out from a western perspective (Van Dyk, 1992). In a country like South Africa, where HIV/AIDS has such an enormous impact, it is important that interventions be developed within the context of the African HIV/AIDS epidemic. Hence the need for this study to investigate and understand how women living with HIV/AIDS experience stigma and how to change their experience of internalised stigma and discrimination.

This study aims at developing a therapeutic intervention model to assist HIV-positive women in understanding their disease, to change the experience of coping with internalised stigma and discrimination, and to empower people living with HIV/AIDS with more adaptive ways of thinking and behaving. It will be

crucial in seeking treatment, adherence to treatment and the adaptation of the women - as well as in understanding their psychological needs.

Cognitive behaviour therapy (CBT) was used to address the internalised stigma and discrimination that HIV-positive women experience. In order to change the way patients think and to promote more realistic and adaptive ways of thinking, cognitive and behavioural methods are used to challenge dysfunctional beliefs (Bea & Tesar, 2002; Beck & Weishaar, 1989; Meyer & Salmon, 1988; Plotnik, 2002; Weiten, 2002; Wilson, 1989). Beck and Weishaar (1989) emphasise that cognitive change can promote behavioural change by allowing the patient to take risks. In turn, experience in applying new behaviours can validate new perspectives.

Through both cognitive and behavioural methods, the patient discovers more adaptive ways of thinking and behaving. The therapist helps patients to see how unrealistically negative the thoughts are, and therefore persuades them to alter their patterns of thinking (Bea & Tesar, 2002; Weiten, 2002). HIV-positive women may for example have “irrational” feelings of failure and worthlessness, which can be addressed and modified according to Wiser, Goldfried, Raue and Vakoch (1996). Thus, this was the theoretical perspective that was utilised in therapy to assist HIV-positive women in dealing with stigma. Through this approach, the patient could learn how to correct faulty cognitive processing so that it would eventually no longer be necessary to depend on the therapist (Bea & Tesar, 2002; Beck & Weishaar, 1989; Kelly, 1987; Wilson, 1989).

Cognitive therapy maintains that the modification of dysfunctional assumptions leads to effective cognitive, emotional and behavioural change. Cognitive therapy is a present-centred, directive, active and problem-orientated approach best suited for cases in which problems can be delineated and cognitive distortions are apparent (Beck & Weishaar, 1989; Plotnik, 2002). The researcher used this approach to develop and assess an intervention model for changing the experience of internalised stigma and discrimination of women living with HIV/AIDS.

1.3 AIM OF THE STUDY

This study aimed to develop and evaluate an intervention model by using an individual cognitive behaviour technique. The objective was to change the experience of internalised stigma and discrimination of women living with HIV/AIDS. Knowledge of this intervention model may enable psychologists to understand HIV-positive people’s experiences of internalised stigma and assist the female patients in coping with their disease. The knowledge gained could be of value in terms of assisting infected people to change the experience of internalised stigma and discrimination, and to enable them to come to terms with this potentially life-threatening disease.

1.4 THE OUTLINE OF THE STUDY

In order to enable the reader to understand how to change the experience of internalised stigma and discrimination of women living with HIV/AIDS, this study was structured as follows:

- Chapter 2 dealt with a review of the literature on HIV/AIDS, stigma and discrimination, which included a definition of key concepts such as the following: signs, symptoms and transmission; the stages of adjustment to the disease; why women are in a negative position; women's emotional experiences of being HIV positive; responding to HIV/AIDS stigma and discrimination.
- In Chapter 3 the researcher focused on theoretical perspectives on how to facilitate change through therapy and especially how to help women to change their experience of stigma.
- Chapter 4 reports on the method of investigation, qualitative and quantitative research, the researcher's role, research design, measuring instruments as well as the method that was used for analysing data.
- Chapter 5 presents the findings of data.
- Chapter 6 contains a discussion of the results and their integration with literature, as well as the conclusion and evaluation of this study, based on the findings of this research. Possible recommendations were made, which may encourage further investigations of stigma related to HIV/AIDS. Possible research projects that could emanate from this research were also suggested.
- Finally, the sources consulted, as well as relevant appendices were listed.

CHAPTER 2

REVIEW OF THE LITERATURE ON HIV/AIDS, STIGMA AND DISCRIMINATION

2.1 INTRODUCTION

Until 1982, no one had heard of AIDS. However, since then it has become one of the most feared diseases in history and has killed millions of people, most of them young or middle-aged. Millions more are infected with HIV – the virus that causes AIDS. Because people with HIV are infectious to others for the rest of their lives, the number of infected people is growing all the time (Whelan, 2002).

In this chapter, the researcher provides an overview of HIV transmission and the impact thereof on the body, which includes the various stages of the illness (biological) that HIV-positive women in this research go through. This is followed by a discussion of the experience of stigma and discrimination (social), together with the women's emotional experience (psychological) when diagnosed as HIV positive. In addition, responses to HIV/AIDS stigma and discrimination are described.

2.2 HIV TRANSMISSION

HIV is present in all the body fluids of an infected person but is concentrated in blood, semen and vaginal fluids. It is present in virtually all body tissues and organs, including the brain, spinal cord, cerebrospinal fluid and breast milk. It can be found in tears and saliva, although these are not considered significant routes of transmission (Hubley, 2002).

Many people are afraid of HIV and AIDS. However, the good news is that it does not easily spread from person to person. Viruses such as those of the common cold or influenza are tough viruses that are able to withstand being blown around in the air and are highly infectious. HIV, on the other hand, is a delicate virus that is easily killed by heat and by drying. A larger dose of virus is needed to spread HIV than other viruses that are spread in a similar way such as Hepatitis B. Four critical conditions must be fulfilled if HIV is to be spread by a particular route:

- HIV must be present in a body fluid such as semen, vaginal fluids, blood or blood products.
- HIV must survive during the period that it is out of the body - this can be a long time in stored blood, but is quite short in most other situations.

- HIV must get into the blood of another person. Skin forms a barrier to HIV, therefore, the virus must enter where the skin is damaged or more delicate, for example through the mucous membranes of the anus and vagina. The acid in the stomach also inactivates the virus.
- Sufficient HIV must be transferred into the other person to make an infective dose (Hubley, 2002).

Therefore, HIV is generally transmitted in three ways: 1) Through sexual intercourse; 2) when HIV-infected blood is passed directly into the body, and 3) from mother to child during pregnancy, childbirth and breast-feeding (De Cock, 1996; DiPentima & Steven, 2005; Evian, 1991; 2003; Hubley, 2002; Klatt, 2005; Mather, 2002; Mayo Foundation for Medical Education and Research (MFMER), 2004; Whelan, 2002).

A person is most likely to pass on the HIV virus to someone else soon after becoming infected with the virus (during the first four to eight weeks), when there is a high HIV viral load, or during the later phases of the infection when symptoms of HIV infection or AIDS appear. This is because there are larger quantities of virus in the blood stream at these times. It is important to note that it is possible to spread HIV at any time during the disease (Evian, 2003).

2.2.1 The Influence of Poverty and Low Socio-economic Conditions

AIDS and other sexually transmitted infections (STIs) are often more common in developing countries. The reasons why low socio-economic conditions promote the spread of STIs (according to Evian, 2003) are as follows:

- Poverty often contributes to the sexual exploitation of women, as they culturally have a more inferior status than men. In many communities, women have very little control over their sexual lives and any attempts to prevent STIs, which in turn give rise to HIV transmission. Women are often forced to engage in transactional sex to earn precious money for food and basic needs, and to help raise their children. Even young girls may sell sex to older men (Natrass, 2004).
- Large-scale unemployment promotes migrant work and family disharmony. This forces people to leave their homes and loved ones, friends and local community life. In the far away places, migrants often find themselves in lonely, unfavourable, hostile or alienating environments. There is a natural need for sex and intimacy, which results in multiple-partner sexual relationships (Natrass, 2004).
- People in poor living conditions often do not have easy access to health care services, and STIs often go untreated and thus spread more easily.
- Poor education and low literacy levels help to keep people ignorant of the ways and means to avoid HIV/AIDS (Natrass, 2004).

- Alcoholism, smoking dagga or the use of drugs to escape everyday hardships can contribute to irresponsible behaviour, resulting in sex with multiple partners.
- Crime and violence are also common in cities and towns and these cause further stress to family and community life.
- Many of the problems discussed above also result in the breakdown of the traditions, customs, beliefs and cultural practises in a community. These practises usually determine the accepted sexual behaviour and constraints in a society. When they have collapsed, it often results in people having multiple sexual partners and practising indiscriminate sex.

2.3 THE IMPACT OF HIV ON THE BODY

Once the human immunodeficiency virus enters the human body, it attaches itself to a white blood cell (WBC). WBCs are those blood cells known as leucocytes that function as part of the immune system and are called CD4 cells. They are the T helper/inducer lymphocytes with CD4 receptors and are important cells that regulate and control aspects of the immune system. They are also called the T4 helper cells and are the main fighters of disease in the body. Whenever there is an infection, CD4 cells lead the infection-fighting army of the body to protect it from falling sick. Damage of these cells can affect a person's disease-fighting capability and general health (United Nations Development Programme /UNDP, 2005).

After gaining a foothold in the CD4 cell, the virus injects its RNA into the cell. The RNA then gets attached to the DNA of the host cell and becomes part of the cell's genetic material. This implies a virtual takeover of the cell. Using the cell's division mechanism, the virus now replicates and produces in large quantities hundreds of thousands of its own copies. These cells then enter the blood stream, get attached to other CD4 cells and continue replicating. As a result, the number of the virus in the blood rises and that of the CD4 cells declines.

Current estimates are that one third of people with HIV are not aware of it yet (Wanted, 2005). A person who becomes infected with HIV will usually pass through various clinical stages that occur over a period of five to 12 years (Evian, 2003). The stages include the asymptomatic phase, when the person has the virus but is well and displays no symptoms of the disease (asymptomatic). During the symptomatic phase, the person experiences mild disease episodes to severe illness (symptomatic), and finally the person dies (details to be discussed in the next section).

HIV slowly damages the immune system and the appearance and manifestation of disease is usually related to the degree of immunodeficiency and the viral load in the body. Anti-retroviral drug therapy (ART) involves the use of drugs that

suppress or prevent replication of HIV, thus significantly changing the course of the disease and prolonging the well and asymptomatic phase. The state of the immune system or that part of the body's structure and function that fights against infections and other foreign recognised bodies, is the best predictor of the patient's risk of developing symptomatic disease. Measuring the number of CD4 cells is currently regarded as the best indicator of immunodeficiency or a weakening in the immune system, in HIV disease and is used to monitor the immune status of the person.

In the absence of the CD4 count, the lymphocyte count can also be helpful – however, it is less specific and less accurate. Even in the absence of these tests, one may rely on the presence of HIV-related signs and symptoms. These include thrush, shingles and Kaposi's sarcoma as indicators of advanced immunodeficiency. AIDS is the advanced, late and final stage of HIV infection and is associated with severe immunodeficiency (Evian, 2003; UNDP, 2005).

The viral load usually rises to a high level soon after HIV infection. This is due to a very rapid multiplication and replication of the virus after infection. As the body develops antibodies to HIV, the virus level in the blood decreases, as the virus is mainly swept into the lymph nodes. The decline in the HIV load usually coincides with the time of sero-conversion and the primary HIV infection. Viral load levels can vary between “undetectable” levels to values exceeding two to three million “copies” per ml of blood (Evian, 2003). Levels below 50 (or even lower) are considered “undetectable”. Although disease progression may differ between people and situations, a typical progression will be described in more detail in the following section.

2.3.1 Primary or Early HIV Infection

In the first three to six months after acquiring HIV infection, there may be a short (one to two weeks) sero-conversion illness, which can cause the following symptoms: fever and headache; tiredness, malaise, arthralgia or myalgia and depression; rash; pharyngitis (sore throat); muscle and joint pains; swollen lymph glands; gastro-intestinal symptoms (such as nausea and diarrhoea) (Alcamo, 1997; DiPentima & Steven, 2005; Dixon, 2002; Evian, 2003; Gilson, 1996; Huble, 2002; Klatt, 2005; MFMER, 2004; UNDP, 2005; Wanted, 2005; Whelan, 2002).

This occurs at the time when the HIV antibody test usually converts from being negative to positive. The clinical condition is then referred to as sero-conversion illness. The sero-conversion illness is often mistaken for a “flu-like”, viral illness or glandular fever, because the signs and symptoms are non-specific. It often passes unnoticed by the person. The HIV anti-body test usually becomes positive four to six weeks after infection. Often, for the first one to five years or more, the HIV test may be the only indication that a person has HIV, with no other signs of illness (Evian, 2003).

The patient usually remains well and asymptomatic, after the initial non-specific symptoms of HIV infection and sero-conversion. This period is referred to as the clinically latent or “silent” phase of HIV infection. The HIV viral load may rise to high levels before the sero-conversion stage and then drop to much lower levels afterwards (Evian, 2003).

The level that the viral load reaches at this stage of the disease is called the “set point” and ART can reduce this set point. It must be pointed out that ART for primary infection are no longer recommended as it was considered in experimental groups in 2003 but was then discontinued as it was regarded by many scientists as irresponsible. A lower set point is likely to result in a lowered viral load in the body and a better prognosis. This “early detection” of HIV is often missed in most patients. It is especially important to be tested after needle stick injuries, rape and other known risky sexual encounters (Evian, 2003). In post-exposure prophylaxis, the individual is not infected by HIV yet and the purpose of the ARVs is to prevent the virus to take hold. The clinically latent or “silent” infection phase will be discussed next.

2.3.2 Clinically Latent or “Silent” Infection – the Asymptomatic Phase

HIV-infected people usually experience a period of good health in which the virus remains clinically “silent” or latent. This phase may last three to seven years (even up to 10 years) (Evian, 2003; UNDP, 2005). Some people stay asymptomatic for anything from one to 15 years, with 10 years being the average in the developed world. However, even though the infection is clinically “silent”, the virus is active in the body and usually causes progressive damage to the immune system. The person is also able to spread the virus during this phase. The CD4 cell count will usually decrease by between 40 and 80 cells per ml of blood per year (Whelan, 2002). The asymptomatic phase is associated with a CD4 cell count of between 500 and 800 cells per ml and even less (Alcamo, 1997; Evian, 2003).

2.3.3 Minor HIV-related Symptoms – the Minor Symptomatic Phase

Between three and seven years after the HIV infection, some patients may develop “minor” signs and symptoms secondary to the infection. These signs and symptoms may include the following: chronic swelling of the lymph nodes – referred to as “persistent generalised lymphadenopathy”/PGL; herpes zoster (shingles); occasional fevers; skin rashes; fungal nail infections; recurrent oral ulcerations, angular stomatitis and cheilitis; recurrent upper respiratory tract infections (Dixon, 2002; Evian, 2003; Hubley, 2002).

The minor symptomatic phase is usually associated with a CD4 cell count of between 350 and 500 cells per ml of blood. The symptomatic phase is described in the following section.

2.3.4 HIV-related Disease – the Symptomatic Phase

After about five to eight years following the HIV infection, the viral load tends to increase progressively. The immune system continues to deteriorate and become deficient. Signs of more HIV-related diseases begin to appear. These signs and symptoms are usually due to overgrowth of some of the body's natural flora with fungal infection and re-activation of old infections (for example, TB and herpes). They are also due to the uncontrolled multiplication of HIV itself. Later, as the immunodeficiency progresses, more frequent and severe opportunistic infections start to occur. Opportunistic infections are illnesses of the body as a result of a weakening of the body's defence. Normally, these infections would not cause a particular disease in a healthy body. This stage of the HIV disease is formally referred to as "AIDS-related complex" (ARC).

Common signs and symptoms of the symptomatic phase are: oropharyngeal candidiasis or vaginal candida infection (thrush); hairy leukoplakia on the tongue; recurrent herpes simplex infection; herpes zoster; acne like bacterial skin infections; persistent and unexplained fevers and night sweats; skin rashes; generalised lymphadenopathy or shrinking of previously enlarged lymph nodes; persistent diarrhoea; cough and shortness of breath; weight loss. The reactivation of TB may also be associated with this stage of infection.

The symptomatic phase is usually associated with a CD4 cell count of between 150 and 350 cells per ml of blood (Evian, 2003; Hubley, 2002; MFMER, 2004; Wanted, 2005). The following section discusses AIDS, the severe HIV-related disease.

2.3.5 Severe HIV-related Disease – AIDS, the Severe Symptomatic Phase

The symptomatic phase usually progresses over the next year or 18 months into the fully developed AIDS phase of the disease. AIDS is associated with a high HIV viral load and severe immunodeficiency. These usually correspond to a CD4 cell count of below 200 cells per ml and to a low lymphocyte count. This allows the development of severe opportunistic infections such as cancers and HIV-related organ damage. These conditions are therefore known as "AIDS defining" illnesses (Evian, 2003; Klatt, 2005; Whelan, 2002). It is at this stage of the disease that the South African government has agreed to provide public hospital patients with ART.

The signs and symptoms of AIDS differ from one patient to the next, depending on which cancer or organ is affected, and are as follows: herpes; seborrhoeic dermatitis; chronic pelvic inflammatory disease (PID); respiratory infection; pneumonia; candidiasis – oral or genital thrush; bowel infection; brain infection; cancers such as Kaposi's sarcoma. Lymphoma may present with enlarged lymph nodes, liver or spleen; lack of energy; severe tiredness, fatigue and weakness; difficulty in sleeping; memory and concentration loss; lack of co-ordination and

personality changes; anxiety and depression – due to suffering and pain; peripheral neuropathy; wasting of body tissue and marked weight loss; difficulty with and pain on swallowing; retinitis and blindness (Alcama, 1997; DiPentima & Steven, 2005; Dixon, 2002; Evian, 2003; Gilson, 1996; Hubley, 2002; MFMER, 2004; UNDP, 2005; Wanted, 2005; Whelan, 2002).

It is clear from the above that AIDS is not a single disease with a characteristic set of signs and symptoms. It consists of and may present with a variety of signs and symptoms, depending on which specific infection or cancer is present. It also depends on which organ is mostly affected. These conditions usually occur late in the course of HIV infection and arise due to the deteriorating immunodeficiency.

AIDS patients often go through stages of being very sick to being reasonably well again (usually due to ART). However, infections tend to re-occur and become more frequent. The body becomes progressively weaker with repeated infection, due to the multiplication of HIV and possibly the development of several cancers. After developing signs and symptoms of AIDS, death usually occurs six months to three years or later (Evian, 2003).

The availability of ART and the prevention and treatment of the opportunistic infections (such as TB, pneumocystis jiroveci pneumonia, candidiasis) can modify the progress of the disease. The patient's wellness can be significantly prolonged by modern ART, which can reduce the severity and frequency of opportunistic infections (Evian, 2003; Whelan, 2002). The women who participate in this research all are on ARV's in a public hospital – that means that they have been through all of these stages and were already sick with a CD4 count below 200. It is thus relevant to understand what they experienced or are experiencing when working with them in therapy. The next section will focus on a discussion about whether every person with HIV can go on to develop AIDS.

2.3.6 Stages of Development of HIV Infection into AIDS

It is not clear whether every HIV-infected patient will progress to develop illness and AIDS. Through the past twenty years it has been found that HIV-infected patients can be rapid or slow progressors (Evian, 2003).

Rapid progressors are people who usually develop immunodeficiency earlier, often within five to seven years after infection. For some, this may be as soon as within three to four years.

Slow progressors generally remain well and active without any disease, and with very little or absent immunodeficiency. They may remain well for 10 to 15 years or more.

Almost 80% of HIV-infected people will have developed AIDS within 12 years of acquiring the infection. On average, it takes about eight years for HIV to progress into AIDS. It seems more likely that most HIV-infected patients will eventually develop severe immunodeficiency and symptomatic disease, but for some it can take up to 15 to 20 years.

Non-progressors are a small percentage of infected people (almost 5%) who remain well and free of immunodeficiency. They may never progress to immunodeficiency and HIV-related illness. Researchers are especially interested to find out why some people's HIV does not progress into AIDS.

The existing health status of a person may influence how long it will take to develop immunodeficiency and symptomatic disease. Diseases like malnutrition, measles, TB and malaria may have an independent immune-depressive effect. This may alter the natural course of the HIV disease (Evian, 2003). Studies suggest that the rate of progression to AIDS is faster in developing countries. This may be because people in these countries are much more exposed to common infectious diseases (Hubley, 2002).

In the previous section, the researcher dealt with the signs and symptoms of HIV/AIDS to promote an understanding of what the women in the study may experience. The researcher will also discuss the emotional reactions of women when diagnosed with HIV, as the present study focused on helping women to deal with these experiences.

2.4 EMOTIONAL EXPERIENCES OF BEING HIV-POSITIVE

In a study conducted in Pretoria by Mokhoka (2000), women who were diagnosed with HIV experienced different types of emotions. Their initial reaction was shock and disbelief. It was difficult for the women to accept the fact that they had to live with HIV.

Anger as a psychological reaction to the onset of chronic illness is often generated by feelings of frustration associated with the illness (Westbrooke & Viney, 1982). Anger is a typical response to the unexpected loss of control over one's life (Giddens & Giddens, 2000). In this case, anger seemed to be mainly directed at the people who were thought to be responsible for infecting the women (Kalichman, 1995). The difference in verbalising and admitting to these feelings of anger seemed to be related to the type of relationship between the women and the persons who infected them (Westbrooke & Viney, 1982).

Anger was often displaced in all directions and projected onto the environment – at times almost random (Kübler-Ross, 1969). Family members who were not thought to be supportive can also be at the receiving end of women's anger.

When a person is diagnosed with HIV, he/she immediately thinks of death. From that moment, that person will also be grieving and mourning some loss, which can be the loss of life associated with an anticipation of death, or loss of time as a result of the now limited life span. Simos (1979) views anger as an integral part of the grieving process. Hate feelings were found to be closely related to anger, with hate also being directed at people who were thought to have infected the participants (Mokhoka, 2000).

These emotional reactions also included feelings of self-blame and guilt for having been infected (Mokhoka, 2000). Self-blame, shame and self-devaluation are among the first emotional responses of a person who is diagnosed with HIV (Chuang, Jason, Pajurkova & Gill, 1992). This type of emotional response is common in women, due to the perception that if they are infected with HIV, they are promiscuous. Guilt feelings also originate from the thought of dying and leaving one's children behind (Bennett, 1990). These feelings can account for much of the pain of the process of mourning (Simos, 1979). Giddens and Giddens (2000) agree that not being in control over a situation can leave one feeling powerless.

Apart from worrying about themselves and their health, women interviewed by Mokhoka (2000) are indicated to have said they have worries about leaving their children behind, which was very hurtful to them. In cases where there is nobody to take care of their children after the parents have passed away, the children's well-being seemed to be the most significant issue on the mother's mind. The thought of bringing shame on their families when the news becomes known to everybody was also painful. Financial factors consequently play a major role in the women's state of mind. Uncertainty about the future in the sense of not knowing how long they still have to live, means they must start saving money for their children.

There were references to sadness and a depressed mood during the interviews conducted by Mokhoka (2000). Depression may be a way of shutting down the emotional system so that it doesn't suffer a dangerous overload (Giddens & Giddens, 2000). For patients living with HIV/AIDS, depression is a common, distressing condition that can interfere with critical self-care behaviour – adherence to antiretroviral therapy (Safren, Hendriksen, Mayer, Mimiaga, Pickard & Otto, 2004). During these phases of depression women felt hopeless and helpless, and just wanted to commit suicide, thinking that they were going to die anyway. Suicide is seen as a way to escape inner pain and depression, rather than working through problems (Giddens & Giddens, 2000). Knowing the facts about the virus and the progression of the disease helped them to understand that they can still live with the virus for a long time, as long as they take proper care of themselves.

Some women mentioned feeling worthless and ashamed of themselves soon after they were diagnosed. The reactions they received from others further

reinforced those feelings (Mokhoka, 2000). People's perception of HIV somehow influences the way HIV-infected people perceive themselves (Siegel, Karus, Raveis & Hagen, 1998). The women seemed to be worried about the way they appear physically, and they attempted to maintain weight in an endeavour to steer attention away from their physical appearance and quell suspicions about their HIV status. They therefore ensured that they would eat enough to be able to retain their body weight. It was essential to the women that people should not be able to tell that they are HIV positive by looking at them.

When pronounced HIV positive, many people feel completely hopeless, as they believe that there are very few options open to them (Orr, 2000). They feel as though their death certificate has been signed and that all they have left to do is to wait to die (Dharapak, 2005). Their feelings of despair are multiplied by the stigma, ignorance and often violence, which continue to underpin the epidemic. People living with HIV/AIDS have had to face being cast out of their families and communities. They have been assaulted both physically and emotionally when having opted to disclose their status (Orr, 2000).

It is of importance to recognise not only the powerful influence of the individual's immediate familial or social context, but also the broader impact of the larger social climate – particularly the negative effects of social stigma, fear of rejection and discrimination (Kaminsky, Kurtines, Hervis, Millon, Blaney & Szpacznik, 1989). According to Mokhoka (2000) women experienced difficulty in sharing the diagnosis with their partners. It seemed easier if the partner knew about his own status already or they discussed getting tested. In cases where the partners did not know, women feared telling them because they were afraid of being rejected. This finding is also confirmed by Simoni, Mason, Marks, Ruiz, Reed and Richardson (1995), who state that individuals contemplating disclosure may also fear a disruption in relationships, particularly by evoking stigmatising attitudes.

It seems that the common perception among men is that if their female partner first tests HIV positive, she must have contracted the virus from elsewhere. When men became the ones to undergo HIV testing first, the women usually found themselves forced to forgive them and care for them. Some women stay with their men because they are dependent on them financially and sometimes have nowhere else to go if they should leave their partners (Paterson, 1996).

The type of treatment that women received from their families determined the way they related to them afterwards. Loss of interpersonal contact, especially with important people like family members, leaves a person with feelings of isolation (Manuel, Roth, Keefe & Brantley, 1987).

2.5 HIV/AIDS STIGMA AND DISCRIMINATION

Siyam'kela (2004) defines stigma as a powerful and discrediting social label that radically changes the way individuals view themselves and are viewed as

persons. Discrimination is the immediate process of applying the stigma at a behavioural or community level (Visser & Makin, 2004). According to Goffman (1963), stigma can be classified as follows:

- Felt or internalised stigma refers to the person's experience of, or fear of being stigmatised. This is a construction of the person and represents the stigma internalised by the affected person. Stigma leads to unwillingness to seek help and access resources (Siyam'kela, 2004). The researcher focused on this form of stigma in his study in order to develop a therapeutic individual cognitive behavioural technique to assist women living with HIV/AIDS to change the experience of internalised stigma.
- Enacted (external) stigma refers to the actual experiences of stigmatisation and incidences of discrimination experienced by the affected person. Many other factors including stigma provides access to discrimination on the basis of HIV status or association with someone who is living with HIV (Siyam'kela, 2004).
- Perceived community stigma refers to the perception a person has of the community's stigmatising attitudes (Goffman, 1963). It was found that HIV-positive women perceive the community to be very negative, although they do not experience high enacted stigma. Thus the question is asked whether the perception of stigma is not overrated in these communities of Atteridgeville and Mamelodi in the Tshwane area (Visser, Kershaw, Makin & Forsyth, 2008). Scambler and Hopkins (1986) also argue that the internalised stigma often precedes rather than results from the enacted stigma. They claim that many individuals reduce the opportunities for enacted stigma in order to protect themselves from discriminatory actions. People with HIV therefore fear to reveal their status and may withdraw from society because they expect that other people will reject them, irrespective of the enacted or real community stigma.

There are four main reasons why stigma is attached to HIV/AIDS (Alonzo & Reynolds, 1995; Parker, Aggleton, Attawell, Pulerwits & Brown, 2002):

- HIV/AIDS is a life-threatening disease, which is perceived as contagious and threatening to the community.
- People are afraid of contracting HIV through casual contact. This is possibly due to lack of information and misconceptions.
- HIV/AIDS is associated with behaviour that is already stigmatised such as sexual promiscuity and drug use – behaviour that is not sanctioned by religious and moral beliefs. That probably results in the perception that HIV/AIDS is the result of deviant behaviour deserving punishment.
- People living with HIV/AIDS are often seen as being responsible for having contracted the disease, which increases the attribution of stigma.

The stigma is therefore born of fear, ignorance, lack of knowledge and social judgement.

The stigma and discrimination perpetuate the culture of silence and fear that surrounds the disease and can prevent individuals from being tested and treated for HIV/AIDS and associated infections. The destructiveness of HIV-related stigma is further compounded by the fact that the status of many people living with HIV/AIDS is already marginalised due to poverty, involvement in sex work, drug use, or other stigmatised activities. In addition, many more who do not know their HIV status live in fear of facing stigma and discrimination, should they contract the disease. HIV-related stigma is increasingly recognised as the single greatest challenge to slowing the spread of the disease. In spite of the increasing awareness that the impact of stigma must be addressed in policies and programmes that are aimed at reducing HIV/AIDS, efforts are impeded by the scarcity of information on stigma and HIV/AIDS. If people can reduce the fear surrounding the risk of contracting HIV/AIDS or its effects, they can be able to reduce stigma. Clearly, some degree of fear of infection, coupled with knowledge about what is likely to transmit the disease and how to prevent this, is important in maintaining people's ability to prevent themselves from being infected. HIV/AIDS-related stigma and resulting discriminatory acts create circumstances that fuel the spread of HIV (CIDA, 2004; Corish, 2005; ICW, 2004; ICRW, 2002b; Keeton, 1999; Siyam'kela, 2004).

In a study conducted by Visser, Makin, Vandormael, Sikkema and Forsyth (in press), a comparison is made of the level of stigmatising attitudes among members of Atteridgeville and Mamelodi communities and what they perceive the level of stigma to be within their communities. The researchers also attempted to determine the relative contributions of socio-demographic characteristics, cultural beliefs and exposure to HIV to stigmatising attitudes. The findings revealed that the level of internalised stigma was significantly lower than perceived levels of community stigma. Participants who were more stigmatising were older, male, less educated and were less knowledgeable about HIV. They were also less likely to know someone with HIV and held onto more traditional cultural view points. While socio-demographic and cultural factors are difficult to change, efforts aimed at increasing people's knowledge and exposure to the epidemic in their community could change the level of stigmatising attitudes within their community. This could have the potential advantage of addressing the epidemic and providing greater support for those living with HIV/AIDS.

It is significant for those who are HIV positive to know that HIV stigma is probably not as prevalent as commonly perceived, and therefore others may be more accepting and supportive than HIV-positive people may anticipate. In actual fact, disclosure to others and making them more aware of the HIV epidemic within their midst could contribute to decreasing the level of stigma within their community (Visser et al., 2008).

The specific social context within which people live materially affects their experience of a chronic illness like HIV/AIDS. Their treatment needs can be shaped by socio-economic factors, the political environment and culturally

mediated ideas about gender, age, sexuality and illness in general. The socio-economic context could even affect access to treatment and whether people experience HIV/AIDS as a long-lasting illness or a terminal one. Often, many of these social factors also affect the nature and strength of stigmatisation of HIV/AIDS. The focus in this section is on how responses to social stigmatisation affect the impact of stigma. It is worth noting that research on stigma and discrimination needs to be part of a broader understanding of people's experiences of and responses to the illness within their ordinary spheres of life (Deacon et al., 2005).

2.5.1 Response to HIV/AIDS Stigma and Discrimination

According to Deacon et al. (2005) most of the disease stigma literature looks closely at the process and functions of stigmatisation from the perspective of the stigmatiser rather than the stigmatised. This is suitable to some extent, given that stigma is initiated by those who stigmatise and perpetuated (to some extent) by entrenched social patterns of exclusion. However, understanding how HIV-positive people experience and respond to stigmatisation is no less important, because the way people respond to stigmatisation is a significant determinant of the impact of stigma. Stigmatised people may, for instance, suffer disadvantage without experiencing any direct discrimination by shying away from situations that they think will be discriminatory. AIDS-related stigma has impacted on the lives of many individuals. Stigma can be internalised and may thus attribute to:

- Withdrawal from society
- Self-doubt
- Lower self-esteem
- Depression
- Harming intimate relationships
- Immuno-suppression
- Even premature death, because it discourages treatment-seeking behaviour (Santana & Dancy, 2000).

The experience of and response to stigma by HIV-positive people thus justify special enquiry to counter the negative effects of the AIDS epidemic. Internalised stigma has often been considered in the literature as a "type" of stigma. Internalisation of stigma or self-stigmatisation involves accepting some of the negative social judgements as part of one's own identity (Deacon et al., 2005).

When others express stigmatising ideologies, HIV-positive people experience the status loss and moral judgements to be projected onto them. This may occur when a person expresses stigma directly to them (direct) or when a person living with HIV/AIDS reads a newspaper in which stigmatising views are expressed (indirect). HIV-positive people may also suffer disadvantage directly or indirectly when discrimination happens. Much of the concern is with the way in which HIV-

positive people act as a result of projecting their direct or indirect experiences of stigmatisation or discrimination into the future (Deacon et al., 2005).

Stigma may not necessarily result in action or discrimination. One would need to investigate stigma and discrimination interrelationships, examining not only “perceived stigma” but also expected discrimination. HIV-positive people may use perceptions of both to plan their actions and many will act on the basis that stigma commonly provides access to discrimination. We sometimes need to research stigma and discrimination as separate concepts, and sometimes we need to investigate their close relationships or how the responses to both could be similar (Deacon et al., 2005).

Miller and Kaiser (2001) suggest that there have been several efforts to distinguish conceptually and empirically among the many different responses people may have to stress. Some of the distinctions that have been suggested as important include distinguishing between voluntary and involuntary responses; emotion-focused and problem-focused coping responses; primary versus secondary control coping efforts; engagement (approach) versus disengagement (avoidance) responses; active and passive coping; cognitive and behavioural coping. The most fundamental distinction between different responses to stress can be made between voluntary coping responses and involuntary responses. This distinction emphasises the fact that not everything a person does in response to stress constitutes coping. People may have involuntary emotional, behavioural, physiological and cognitive responses to stress that do not serve to regulate or modify stressful experiences. These involuntary responses may be conscious or subconscious but they are experienced as being largely outside of the person’s control. People respond to stigma and other stressors in a number of ways, and feedback from one response alters other responses (Miller & Kaiser, 2001). It was also shown in a study that the way HIV-positive women think about HIV-related stressors is an important factor that may account for individual variability in the ability to maintain a sense of subjective well-being in the face of a devastating fatal disease (Moneyham, Seals, Demi, Sowell, Cohen & Guillory, 1996).

Both voluntary coping responses and involuntary responses to stress can involve engagement or disengagement with the stressful event or problem. This distinction is derived from older distinctions between fight (engagement) and flight (disengagement) responses and between approach and avoidance responses. Thus, engagement with a stressor does not necessarily imply conscious, volitional, higher-order cognitive processing (Miller & Kaiser, 2001).

Miller and Kaiser (2001) further indicate that not all responses to stigmatisation are necessarily maladaptive. In fact, they may also represent positive ways of coping with the stressor. It will be shown below how other HIV-positive people have overcome the harmful consequences of stigmatisation. According to Shih

(2004), the following positive responses to stigma are identified, which can be used in therapy simultaneously to assist HIV-infected women to cope.

- Compensation

Miller and Major (2002) mention that stigmatised individuals develop skills to compensate for stigma. These skills assist them to achieve their goals and overcome the disadvantages associated with the stigma. One compensation strategy that stigmatised individuals adopt is to try harder by being more persistent or assertive in paying closer attention about how they present themselves. Dion and Stein (1978) state that researchers found that unattractive female adolescents were more assertive when they tried to influence their peers than were attractive female adolescents. Stigmatised individuals may also try harder to be more likeable.

- Strategic interpretations of the social environment

Stigmatised individuals also strategically manipulate their interpretations of their social environment to protect their sense of self-worth. For instance, they make selective social comparisons. Rather than comparing themselves to individuals from advantaged groups who tend to have better outcomes, stigmatised individuals compare themselves to members of their own group who experience similar or worse outcomes. Seeing that one is doing just as well or even better than the others in similar circumstances increases one's sense of self-efficacy (Shih, 2004).

- Multiple identities help stigmatised individuals to handle prejudice and discrimination

Stigmatised individuals can draw upon their alternate identities to protect themselves from stigma (for example, consider an African, female, Christian attorney, who can simultaneously be identified by her ethnicity, gender, religion, occupation or any combination of these identities). Most work on social identity and stigma focuses on a single identity, usually the stigmatised identity. However, individuals carry multiple identities in the real world (Hewstone, 2000). Thus, while stigmatised individuals can be defined by their stigmatised identities, they can also be defined by a host of other identities. Moreover, it was found (Shih, 2004) that multiple identities protect psychological well-being. Individuals with greater self-complexity had more resilience to handle stress-related illnesses and depression, had more opportunities to gather support and felt greater life satisfaction. These benefits were also found for individuals who possessed identities that were not valued. Identity switching is one process through which multiple identities protect the individual's psychological well-being. Since stigmas are social

constructions, certain identities may be stigmatised in one social context but not in another. Thus, individuals can strategically emphasise identities that are valued and de-emphasise identities that are not valued in any given social context (Shih, 2004).

- The adoption of an “empowerment” model as opposed to a “coping” model when dealing with stigma

Stigmatised people view overcoming the adversities associated with stigma as an empowering process rather than as a depleting process. This discussion underscores the significance of adopting an approach to gain a fuller understanding of the experience of being stigmatised (Shih, 2004).

Researchers propose two models to account for the consequences of adopting these protective strategies and developing resilience. The first responses to stigmatisation may be considered either maladaptive or adaptive, depending on circumstances and on who makes the judgement. Although avoidance-coping mechanisms are usually thought of as maladaptive in the literature, HIV-positive people in a South African study (Stein, 1996) derived benefit from some forms of avoidance coping such as non-disclosure and repudiation of negative ideas about HIV and about their HIV-positive status. These coping mechanisms do not necessarily constitute denial of HIV-positive status, but an endeavour to reject its stigmatising connotations. Stein (1996) is of the opinion that non-disclosure of HIV-positive status may be functional to the HIV-positive person’s privacy and peace of mind, yet it may also be seen as a maladaptive response because it is not an “active” work-through and acceptance of the illness. In the absence of safer sex practises, non-disclosure to sexual partners may also put them at greater risk of contracting the virus.

Deacon et al. (2005) argue that instead of blaming HIV-positive people for failing to respond to stigma, it may be better to focus on finding out what responses people find most useful and why so. We might also direct our attention towards addressing key areas of risk rather than tarring all avoidance-coping mechanisms with the same brush. People react differently to different types of stressors and in different circumstances. Groups of people with a history of stigmatisation sometimes develop common coping mechanisms over a period of time. Deacon et al. (2005) warn that we should also be cautious of describing all behaviour of HIV-positive people in terms of HIV or related stigma. A number of factors influence people’s problems, identities and behaviours, and not just their stigmatised status. HIV-positive people often complain that people assume “the virus” takes over their whole personality.

2.5.2 Internalisation of Stigma or Self-stigmatisation

The researcher will describe self-stigmatisation as a response by HIV-positive people to stigmatisation as suggested by Deacon et al. (2005). Since HIV-positive people generally have some experience or expectation about HIV and how society stigmatises them or perceives them to be, they react by conforming to or resisting this framework. Conforming involves internalisation of stigma or accepting society's negative judgement of one's identity as HIV positive. This is psychologically very damaging because it can reduce the self-esteem of the stigmatised person, which will possibly affect the way he/she responds to the illness, which can reduce the incentive to challenge stigmatisation or discrimination. In addition, this can have undesirable consequences for the individual and the public health programmes, for it possibly reduces self-esteem and discourages being tested for HIV/AIDS, disclosure and the seeking of treatment.

A hidden stigmatised status (concealable stigma) can be very damaging too. Goffman (1963) differentiates between being discreditable (having an attribute that will be stigmatised if it were revealed, but choosing not to disclose it) and being discredited (having a visible stigma, or having disclosed a stigmatising attribute). Hiding or revealing a previously hidden stigma can cause bigger psychological distress than revealing a stigma that has not been, or cannot be hidden. Smart and Wegner (1999) refer to this activity as "passing" and observed that being able to conceal a socially devalued aspect of the self may be viewed by the people with these types of stigmas as highly advantageous in social interactions. It may enable them to minimise the impact that their stigma has on others' judgements of them and to be accepted as "normal". Attempting to influence what is revealed or not revealed about oneself in social interaction, however, demands a great deal of mental control. In the effort to hide something significant about themselves, individuals who have concealable stigmas may face an internal struggle that may have serious costs. People who try to hide their status experience greater anxiety than those who reveal it. This was also shown in a study conducted by Smart and Wegner (1999) about eating disorders of anorexia nervosa and bulimia. The same may be applicable to HIV-positive people.

Having concealable stigma is likely to affect even the types of social relationships in which people with these kinds of stigmas choose to become involved. Hiding the characteristic for which they are stigmatised by others allows them to assimilate into mainstream community life. At the same time, one of the consequences is that they avoid associating with other similarly stigmatised people. In doing so, they deprive themselves of many of the benefits such as the social support, social services and social relationships that come with being open about the stigma. In addition, they are unable to engage in downward social comparison because they are likely to want to avoid others who may have a characteristic for which they are more stigmatised than they are. This is in an

effort to avoid being associated with the stigma and possibly being implicated in processing it (Smart & Wegner, 1999).

Therefore, stigmatisation influences the way people negotiate their own identity and the way they behave, whether or not their HIV status is revealed to others. Self-stigmatisation is generally considered a maladaptive response to stigma by Miller and Kaiser (2001). But if self-stigmatisation is so damaging, the question arises as to why people do it to themselves? Self-stigmatisation is a consequence of repressed anger as a result of being stigmatised. But this is not a useful way of understanding how it happens, as it ignores the social dimension – specifically, the fact that people are socialised prior to self-stigmatisation.

Accepting the stereotypes of the community about a disease may result in internalisation once people acquire that disease. In the absence of alternative frameworks that are publicly supported by society, people may be unable to reconceptualise their status as non-stigmatising. To continue to accept society's definition of deviance may also require that people's sense of belonging within a society be reinforced. If such people "repent" or "reform" they may be accepted once again (Link & Phelan, 2001). In an effort to resist self-stigmatisation, HIV-positive people may deploy an overly positive identity that leaves little room for dealing with illness and psychological distress.

A strong, positive HIV identity has an appeal in South Africa, according to Soskolne, Stein and Gibson (2003), where the widespread nature of the epidemic makes it difficult to limit risk to marginalised outgroups. Because of the nature of the illness, which almost always leads to illness and premature death in the absence of effective treatments, there are difficulties inherent in maintaining a wholly positive view of HIV-positive status that focuses on strength and good health. An HIV-positive identity does not leave space for speaking about psychological distress and sickness associated with the disease or for preparing for the phase of ill-health and later death, even where people do have access to treatment. It can also cause anxiety as HIV-positive people feel they have to appear healthy even when they may not be. It is therefore significant to integrate some of the negative and painful aspects of life with HIV/AIDS within a more nuanced identity for an HIV-positive person.

There are many disorders, behaviours and medical conditions that are potentially stigmatising in this society. A common strategy for those who have these stigmas is to attempt to keep this information about themselves hidden and thus avoid the questions and adjustments of others as much as possible. People who hide their status may be struggling a great deal more than it appears. Although they may escape the immediate damage of negative social behaviour and evaluation, they may bring the conflict into their own minds, as it were, and thus become pre-occupied with covering up what no one can see (Smart & Wegner, 1999).

2.5.3 Expected Stigmatisation and Discrimination

Perceived or expected stigma and discrimination is the second issue concerning HIV-positive people's responses to stigma. Stigmatised people can directly experience stigma and discrimination if their status is known, but their perceptions of stigma are influenced by how they identify themselves (as members of a stigmatised group) and how they perceive others (as stigmatising). Their level of exposure to stigma and discrimination and what they have already experienced, read about or heard of, can affect their perception of how much it is going to affect them in the future.

The levels of expected stigmatisation and discrimination can materially affect the self-esteem and behaviour of HIV-positive people. The individuals' perceptions of stigma account for the important differences seen in the impact of an illness on the self. Higher perceived stigma reduced the probability of disclosure of HIV-positive status in African-American women in the United States (US). Lichtenstein (2003) shows that perceived levels of stigma may also have a negative effect on willingness to go for voluntary counselling and testing (VCT) and treatment.

It is indicated by some research that levels of stigma perceived by HIV-positive people tend to be higher than "actual" levels of stigma. Green (1995) found that HIV-positive people generally had more liberal attitudes towards HIV-positive people than the general public, but felt that attitudes towards them were far less liberal than stated by the general public. Visser and Makin (2004) suggest that perceived stigma played a bigger role in determining HIV-positive women's experience of community stigma than did enacted stigma or community support.

Shisana and Simbayi (2002) are of the opinion that it is dangerous to assume that there is necessarily less stigma and discrimination in the general public than HIV-positive people think, because it is very difficult to measure the amount of probable stigma and discrimination in the public sphere. The mismatch between perceived and reported stigma could instead suggest that the general public under-report stigma against HIV-positive people, a factor that could explain the very low reported levels of stigma in the Nelson Mandela/Human Sciences Research Council (HSRC) study.

One needs to examine the situation from the perspective of HIV-positive people, instead of concentrating only on the negative impact of high levels of expected stigmatisation and discrimination on necessary public health goals (e.g. persuading members of the public to go for VCT and treatment and disclosing their status). HIV-positive people might, for example, choose to hide their status to avoid discrimination – simply asking people to disclose, without offering extra support or an effective barrier to discrimination, will not remove this disincentive. In their attempt to focus on the experience of stigma by stigmatised people, researchers need to be careful not to use research to assign fault to stigmatised

people for seeing stigma and discrimination that does not really exist, or to patronise HIV-positive people for not confronting it, such as through disclosure of HIV status. HIV-positive people can also be assisted in selectively disclosing to people that can support them in order to prevent further HIV transmission, although the difficulty in doing so because of potential stigmatisation is acknowledged.

The impact of stigmatisation cannot be understood by measuring what supposedly HIV-negative people say they think about HIV-positive people or how they intend to act towards them, because HIV-positive people respond to stigma and discrimination based not only on their own experiences, but also on what they encounter in the media and hear from other people. Expected stigmatisation and discrimination could be an even greater barrier to those living with HIV in accessing treatment and support than levels of reported or actual stigma or discrimination might suggest. Expected stigma and discrimination is thus a significant but under-researched area (Deacon et al., 2005). The following section will deal firstly with categorising differential treatment and secondly with differential treatment versus discrimination.

2.6 INTERVENTIONS TO ADDRESS STIGMA AND DISCRIMINATION

Discrimination is the basis for most of people's concerns about stigma. In this section, the researcher differentiates between positive and protective kinds of differential treatment on the one hand and unfair discrimination on the other. Because of the conflation of stigma and discrimination, existing research measures intended discrimination – what people mention they will do – as an index of stigma. All unfair discrimination against HIV-positive people is commonly associated with stigma. It is important to avoid defining stigma in terms of discrimination, or discrimination in terms of stigma, because discrimination is not always caused by stigma and is not a good measure of the impact of stigma. Stigmatisation may have negative effects (increasing expected stigmatisation and discrimination) without actually resulting in discrimination. In an attempt to combat the effects of stigma, one should differentiate between situations in which stigma directly causes discrimination and situations in which discrimination is caused by other factors such as sexism, racism or resource concerns. In doing research about discrimination, one needs to find out more about why people intend to discriminate and how intended discrimination relates to action (Deacon et al., 2005).

2.6.1 Categorising Differential Treatment

Differential treatment can be categorised under four aims, according to Deacon et al. (2005): redress, prevention of infection, social distancing and the balancing of social contributions.

2.6.1.1 Redress

Redress refers to situations where disadvantages have been conferred on a group of people by physical differences or cultural prejudice, and societies feel the obligation of redress, as it would be described below. For example, in the race, gender and disability fields, the existence of historical discrimination and the effects of physical differences have on occasion been addressed deliberately. This has been addressed by employment equity programmes, by providing women with guaranteed maternity leave or by providing separate track and field events for those athletes with physical disabilities. HIV-positive people or disabled people may on other occasions receive disability benefits to offset loss of income or to meet specific additional needs. The main problem with providing disability grants on the basis of illness is that, in an environment of grinding poverty and high unemployment such as our country, it provides a perverse incentive to stay sick and possibly even to get sick in order to benefit from the grants (Nattrass, 2004). Such a choice could result in many people shifting between disability grants and AIDS treatment, with the result that the treatment regimen will be a lot less effective and more conducive to drug resistance (Boule, 2003).

2.6.1.2 Preventing Infection

Some kinds of differential treatment for HIV-positive people (rejection of their blood products for transfusions) are validated by medical science while others are invalidated (refusal to shake hands with or hug HIV-positive people). Ignorance of scientifically validated modes of spreading HIV may result in unfair discrimination. Even if strategies are likely to be effective, measures to prevent infection have to be balanced against other factors such as cost and human rights issues. For instance, asking patients' HIV status before a major operation may enable medical staff to be protected against the virus and it may be effective for them. However, this might constitute the violation of HIV-positive persons' rights, especially if they are unwilling to be tested.

2.6.1.3 Social Distancing

Social distancing occurs in cases where HIV-positive people are judged to be promiscuous or immoral. Social distancing is also related to fear of casual transmission. HIV-positive people may experience varying kinds and degrees of status loss and discrimination. For instance, they may be excluded from a religious community. Such a form of discrimination is a direct consequence of stigmatisation, which assists to affirm risk-free identities by projecting negatively defined characteristics and risky behaviours onto other groups.

2.6.1.4 Balancing Social Contributions

Other kinds of discrimination – for instance loss of the right to medical aid, pension, life insurance benefits and education – have been based on lower expected contributions to society by HIV-positive people and higher expected burdens on the family or the public purse. Because of its violation of the human rights of HIV-positive people, such discrimination has been challenged.

2.6.2 Differential Treatment versus Discrimination

Given the long history of using biological differences based on race, gender and disability to justify unfair discrimination, one should be cautious when determining what differential treatment is actually warranted by the threat of infection. Discrimination that is aimed at preventing infection is sometimes based not on actual risk of HIV infection, but on incorrect scientific knowledge or on an overestimation of the potential risk. For instance, HIV-positive patients in US hospitals were at first treated as though the condition was highly infectious, and some people still think that HIV can be spread through ordinary social contact such as touching, hugging, sharing eating implements and using same bathrooms - this is known as an “instrumental stigma” (Herek, 2002).

In an endeavour to understand whether differential treatment is discriminatory (fair or unfair), one has to recognise that there is a difference between judging public health discourses and related public health measures on the one hand, and judging individual discourses and actions on the other. In the personal sphere it is acceptable to make personal choices to meet personal needs and reduce personal risk. Few public health professionals would consider it to be unfair discrimination if an individual were to refuse to have sex with a person openly living with HIV/AIDS (with or without a condom) because he/she wishes to avoid any risk of contracting the virus or, indeed, wishes to avoid increasing his/her own viral load if he/she is also HIV-positive. In the presence of other STDs, the same would be true regarding individual sexual decision making. Unfair discrimination would involve unnecessary measures to reduce risk (for example, refusing to shake hands or hugging) or moral judgements (such as claiming that a person contracted HIV because he/she was promiscuous). The rejection of HIV/AIDS stigma is based on the understanding that all acts of social exclusion relating to HIV/AIDS are not only morally wrong but also counterproductive to effective HIV/AIDS prevention and treatment (Stein, 2003).

On the other hand, public health strategies against the spread of the HIV/AIDS pandemic generally avoid singling out HIV-positive people because this would further stigmatise them, contravene their human rights, and discourage public co-operation, VCT and disclosure. Equality of treatment is a crucial gauge of the acceptability of public health measures in the public health context, even where these are designed to reduce the chances of some people infecting others (Deacon et al., 2005).

Differential treatment may have adverse consequences within a stigmatising society even if it is aimed at redress or the prevention of infection. The difficulty with current public health programmes in relation to stigma and discrimination is not that they single out HIV-positive people for special treatment. In fact, the problem is that guidance on how to remain HIV negative (for instance, abstaining, being faithful) seems to support the stigmatising notion that people who have HIV are promiscuous. It is, however, true that the more sexual partners' people have, the more likely they are to contract HIV from someone (epidemiological risk). It is equally true that HIV can be contracted from a single sexual encounter with an HIV-positive person, even if that person happens to be one's only sexual partner (individual risk). HIV is not caused by promiscuity – it simply happens to be transmitted sexually, as well as in other ways such as HIV-infected blood being passed directly into the body (blood transfusion) and from mother to child during pregnancy, childbirth and breast-feeding (De Cock, 1996; Evian, 2003; Hubley, 2002; Klatt, 2005; Whelan, 2002).

Skinner (2002) expresses the view that the promotion of condom use as a means to combat the spread of HIV infection has also assisted, paradoxically, to stigmatise condom use (“people who use condoms are people who have slept around or who think their partner has slept around”). Where public health measures do single out HIV-positive people for special services (for instance, special ARV clinics, provision of formula feeds for HIV-positive mothers or the provision of certain medicines), these often become markers of HIV-positive status and are stigmatised – called secondary stigmatisation.

In understanding the impact of stigma, Deacon et al. (2005) recommend that one needs to conduct research not only on unfair discrimination and on HIV-positive people's perceptions of stigma and discrimination, but also on the unintended consequences of legitimate forms of differential treatment in public health programmes and campaigns.

In researching discrimination about what forms of differential treatment constitute discrimination, one needs to be clear about why they are unfair and whether, in specific cases, they are caused by stigma or other factors. HIV/AIDS activists and other people have assisted to expand the notion of discrimination to include transgressions of the human rights of HIV-positive people. This would, for instance, include refusal of employment to an HIV-positive person on the grounds that an HIV-positive person is likely to die sooner than an HIV-negative person. Such an example would not only be unfair because it transgresses the human rights of an HIV-positive person, it would also be unfair because other diseases such as cancer are less easily detected in their early stages and may be equally dangerous to someone's career.

Human rights issues raise an interesting question concerning the role of the household in sustaining a person living with HIV/AIDS. For example, decision makers in households make triage-like calculations about how likely a sick



household member is to recover and how much it is costing to treat and feed him/her relative to household income. It would be detrimental to mention that such discrimination would be legitimate, since the household is supposed to be the one place where people are being unconditionally cared for. Discrimination of this kind (for example, the withholding of food) happens quite frequently, especially in resource-poor situations where even free treatment is too expensive or difficult to access. The financial benefit of receiving a disability grant while a sick person is alive is weighed against the cost of special food for the invalid and the potential income from life insurance or funeral benefits on death.

This section has focused on internalisation of stigma, expected stigma and discrimination. Discrimination in this chapter has been indicated to be a significant area of investigation that has been under-researched because of the conflation of stigma and discrimination in the literature and the use of survey data on intended discrimination as a measure of both. Four main categories of differential treatment have been discussed and all these forms of differential treatment are worthy of investigation – both to assist the general public to differentiate between fair and unfair differential treatment, and to understand the potentially negative impact of certain well-meaning public health programmes and campaigns within a stigmatising society (Deacon et al., 2005).

In the next chapter the researcher focuses on the theoretical perspectives on how to facilitate change through psychotherapy, and especially on how to help women to change their experience of and reaction to stigma.

CHAPTER 3

THEORETICAL PERSPECTIVES ON HOW TO FACILITATE CHANGE THROUGH PSYCHOTHERAPY

3.1 INTRODUCTION

Many schools of thought offer ideas about how to do psychotherapy. Therapists with various theoretical orientations use different methods to produce significant changes in patients. Since problems are complex and people are complex, what helps one person will not necessarily help another. The solution for a problem that stems from a physiological cause will necessarily be different from one for a problem arising from a troubled family environment (Weiten, 2002).

Psychoanalysts believe that patients overcome their problems by becoming aware of and dealing with underlying unconscious conflicts that are played out in the therapist-patient relationship. Insights into these conflicts are used to help resolve them (Bea & Tesar, 2002; Gaylin, 2000; Smith, 2000). In comparison, client-centred therapists focus on emotional experiences and the belief that a patient has the capacity to actualise and reach his or her full potential. The patient, and not the therapist, is seen as responsible for change, because the therapist's task is to be nondirective and to show compassion and positive regard in helping the patient reach his or her potential (Plotnik, 2002). In systems therapy, the therapist effects change in the relationship by changing patterns of interaction. Thus the therapist changes the context instead of the system itself. Together with the patient, the therapist creates a new meaning or alternatives for the patient.

For the purposes of this chapter, the researcher has delved into cognitive therapy, behaviour therapy and cognitive behaviour therapy (CBT). The latter is the therapy that was used for this study to assist HIV-positive women to deal with internalised stigma and discrimination. The researcher also motivates why this theory was relevant in changing perceptions of stigma. CBT is based on the assumption that maladaptive thoughts and behaviours are learned from experience and that they can be modified through corrective experiences (Bea & Tesar, 2002). This is the reason why this therapy was chosen as a framework for this study.

3.2 COGNITIVE THERAPY

Cognitive therapy was developed by Aaron T. Beck in the early 1960s as a structured short-term present-orientated psychotherapy for depression, directed

towards solving current problems and modifying dysfunctional thinking and behaviour (Beck, 1995). Beck was trained in psychoanalytic techniques and used them to treat patients, many of whom were suffering from depression. When he asked patients to free-associate, he noticed that depressed patients often expressed negative or distorted thoughts about themselves, such as “I’m a failure, no one likes me, nothing turns out right”. These are similar to the thoughts expressed by HIV-positive people that the researcher has noticed. What caught Beck’s attention was how patients would express a string of negative thoughts almost automatically, without paying much attention. He reasoned that these automatically occurring thoughts had a great impact on the patients’ lives, such as by:

- Lowering their self-esteem
- Encouraging self-blame
- Encouraging self-criticism

Beck devised his form of cognitive therapy to stop these thoughts and treat depression and other problems (Plotnik, 2002).

Cognitive therapy is defined as an insight therapy that emphasises the recognition and changing of negative thoughts and maladaptive beliefs (Weiten, 2002). Cognitive therapy assumes that people have automatic negative thoughts that occur to them without much notice. Automatic thoughts may be described as a stream of thinking that coexists with a more negative flow of thought patterns (Beck, 1964). By continually repeating these automatic negative thoughts, people colour and distort how they perceive and interpret our world and influence how they behave and feel (Clark & Steer, 1996; Hollon, DeRubeis & Evans, 1996; Moorey, 2000). The basic assumption is: what you think influences how you feel (Beck, 1995). Cognitive therapy is aimed at modifying underlying core beliefs. Core beliefs are the most fundamental level of beliefs; they are global, rigid and over-generalised (Beck, 1995). HIV-positive patients, for example, quickly assimilate negative information about themselves and block out positive information or affect. They also recall negative information much better than positive input (Beck, 1991).

Cognitive therapy is very specific and it focuses on measurable results or behaviour. The basic assumptions are that our automatic, irrational thoughts and beliefs can colour our feelings and actions, distort our perceptions, and result in various psychological and emotional problems. Cognitive techniques include patient monitoring and identifying automatic negative, irrational thoughts and replacing them with positive ones (Beck, Wright, Newman & Liese, 1993; Moorey, 2000; Plotnik, 2002).

Negative things we say to ourselves, such as “nothing ever goes right”, “I’m a failure” or “everybody criticises me”, can bias and distort our thoughts and feelings. Cognitive therapy makes a person aware of, and can be a way to assist

someone to change negative self-statements (Hollon et al., 1996; Papalia & Olds, 1988; Plotnik, 2002; Wiser et al., 1996).

Cognitive therapy teaches the patient how certain thinking patterns are causing symptoms – by giving a distorted picture of what is going on in life, causing the patient to feel anxious, depressed or angry for no good reason, or provoking him/her into ill-chosen actions (Beck, 1995; Bush, 2003; Dobson & Block, 1988). For instance, an HIV-positive woman's view of the world may dampen her mood and probably hinder more effective social or interpersonal action. Thus, with cognitive therapy she should be assisted to act more constructively (Wiser et al., 1996).

Cognitive therapy stresses the importance of each individual's perception of external events rather than the direct influences of the environment itself. Modification of these abnormal assumptions and perceptions can aid alterations of problematic behaviour by emphasising the casual role of private thoughts, beliefs, irrational ideas and assumptions in the production and maintenance of abnormal behaviour (O'Sullivan, 2000). Cognitive therapy aims not only to correct faulty information processing but also to modify assumptions, and so reduce vulnerability to further psychological disturbance (Beck et al., 1993; Moorey, 2000).

Cognitive therapy fosters change in patients' beliefs by treating beliefs as testable hypotheses to be examined through behavioural methods jointly agreed upon by patient and therapist. The cognitive therapist does not tell the patient that the beliefs are irrational or that the beliefs of the therapist should be adopted. Instead, the therapist asks questions to elicit meaning, function, usefulness and consequences of the patient's beliefs. The patient ultimately decides whether to reject, modify or maintain all personal beliefs, being well aware of their emotional and behavioural consequences (Beck & Weishaar, 1989; Wiser et al., 1996).

Cognitive therapy is not a substitution of positive beliefs for negative ones. Cognitive therapy is based in reality, not in wishful thinking. Cognitive therapy does not maintain that people's problems are imaginary but that patients may have serious social, financial or health problems as well as functional deficits. In addition to reality problems, patients have biased views of themselves, their situations and their resources, which limit their range of responses and prevent them from generating solutions (Bea & Tesar, 2002; Beck & Weishaar, 1989).

Cognitive therapy is a present-centred, directive, active, problem-orientated approach best suited for cases in which problems can be delineated and cognitive distortions are apparent. It is not designed for "personal growth" or as a way to understand one's past. It has wide-ranging applications to a variety of clinical problems. The cognitive factors that play a key role in the development of many disorders and techniques to produce change are outlined below.

3.2.1 Important Cognitive Factors

Beck has identified a number of specific maladaptive thoughts that contribute to various symptoms such as anxiety and depression (Beck et al., 1993; Hollon et al., 1996; Plotnik, 2002):

- Thinking, “I’m a failure” after doing poorly on one test is an example of over-generalisation, which is making blanket judgements about oneself on the basis of a single incident.
- Thinking, “most people don’t like me” is an example of polarised thinking, which is sorting information into one of two categories – good or bad.
- Thinking, “people always criticise me” is an example of selective attention, which is focusing on one detail so much that you do not notice other events such as being complimented.

Beck believes that maladaptive thought patterns cause a distorted view of oneself and one’s world, which in turn may lead to various emotional problems (Plotnik, 2002). People suffering from emotional problems are often trapped by a particular negative or unhelpful way of looking at their situation and can only see this way of interpreting it (Beck, 1991; Salkovskis, 1996). An HIV-positive woman, for example, might feel powerless about her HIV-positive status and see herself as being isolated and rejected by loved ones. The role of the therapist is to help such a person explore whether or not there might be alternative ways of appraising her situation. Thus, the primary goal of cognitive therapy is to identify and change maladaptive thoughts. The researcher will now dwell on the cognitive techniques that are used by therapists to change maladaptive thoughts in order to show an understanding of the ways therapy can influence behaviour.

3.2.2 Cognitive Techniques

Cognitive therapy aims to change thought patterns that, in turn, play a significant role in influencing behaviour and emotions. In cognitive therapy, patients are told how their maladaptive thoughts and irrational beliefs can result in feelings of depression, anxiety or other symptoms. For example, an HIV-positive woman’s feelings of being useless and rejected by significant others can lead to depression. Patients are made aware of how to monitor their thoughts and beliefs. They are also showed how to recognise maladaptive thought patterns such as overgeneralisations and polarised thinking, and how to substitute them with rational thought patterns (Plotnik, 2002; Salkovskis, 1996; Wiser et al., 1996).

Cognitive therapists are actively involved in determining the pace and direction of treatment. They usually talk extensively in therapy sessions. Therapists may argue openly with patients as they try to persuade them to alter their patterns of thinking (Weiten, 2002). Some techniques used are the following:

Distancing and distraction: These strategies are used by therapists in order to help the patient to get some distance from the constant flow of maladaptive thinking. Distancing the patient from her automatic thoughts helps to reduce the strength of the negative emotional response. Counting negative thoughts, explaining the rationale and defining problems all help to achieve some distance and perspective. Distraction reduces the frequency of automatic thoughts. Getting the patient to engage in mental or physical activity, which moves the attention away from the negative thoughts to something else, can assist in doing this (Moorey, 2000; Salkovskis, 1996).

It is usually recommended for the patient to evaluate her automatic thoughts on the spot and to modify her thinking. In many situations, however, this strategy is not feasible, and refocusing attention, distraction, or reading coping cards are indicated (Beck, 1995).

Coping cards: They are note-cards that a patient keeps nearby (often in a desk drawer, pocket or purse, or posted on a bathroom mirror, refrigerator or car dashboard). The patient is encouraged to read them both on a regular basis (for example, three times a day) and as needed. These cards can take several forms, three of which are described here: 1) Writing a key automatic thought or belief on one side with its adaptive response on the other; 2) devising behavioural strategies to use in a specific problematic situation, and 3) composing self-instructions to activate the patient (Beck, 1995).

Positive self-statement logs: Positive self-statement logs are simply daily lists of positive things the patient is doing or items she deserves credit for. As with all assignments, the therapist first explains the rationale. Completing positive self-statement logs early in therapy also helps prepare patients for the later task of uncovering positive data for the core belief (Beck, 1995).

Challenging automatic thoughts: This strategy aims to change the patient's thinking by challenging the validity of the cognitions. Techniques can be behavioural, for example setting up an experiment, or cognitive, for example looking for the evidence in favour of and against a maladaptive belief (Moorey, 2000; Wiser et al., 1996).

Identifying negative automatic thoughts and changing underlying assumptions: The therapist teaches the patient to observe and record negative automatic thoughts. Initially the concept of an automatic thought is explained: it is a thought or image that comes to mind automatically and seems plausible, but on inspection is often distorted or unrealistic. Thoughts occurring to the patient during the session can be used to illustrate this, for example, an HIV-positive woman might say "I don't know why I am still living". The implications of these thoughts will be explained to the patient in order to see the correlation of her thoughts and depressive feelings. The patient is then given the homework task of collecting and recording negative automatic thoughts. An HIV-positive patient will

be asked to monitor depressed mood, recording the situation that triggered a worsening of depression, and the thoughts associated with it. Identifying thoughts may also be therapeutic in its own right, since merely recording negative thoughts sometimes reduces their frequency. Patients should try to record their thoughts as soon after the stressful event as possible, when it is fresh in their mind. The strategy of changing underlying assumptions assists to challenge the rules that guide the patient's maladaptive behaviour (Moorey, 2000). For instance, an HIV-positive woman might think that she is useless because she contracted the virus and the advantages and disadvantages of her assumption can be explored, reasoning can be used to challenge the assumption and a behavioural experiment can be arranged to test it out.

In challenging a particular cognition, a therapist might employ several cognitive and behavioural techniques.

Socratic questioning: Cognitive therapy helps patients to identify and then modify their maladaptive thoughts. The patient and therapist are co-investigators trying to uncover the interpretations and evaluations that might contribute to the patient's problems. This is an inductive process of guided discovery. Wherever possible, the therapist asks questions to elicit the idiosyncratic meanings that give rise to the patient's distress and to look for the evidence that support or refute the patient's beliefs (Moorey, 2000). Socratic questioning promotes insight and rational decision making by making the patient aware of important information. Most important, this process shapes thinking through active questioning and selective reflecting. The goal of the Socratic Method is for the patient to learn to think independently and rationally (Beck et al., 1993).

Homework assignments: To a large degree, success in therapy is facilitated by the completion of formal and informal homework assignments. Formal assignments involve the practise of cognitive and behavioural techniques between sessions (Beck et al., 1993).

Modifying negative automatic thoughts: When the patient has learned to identify the maladaptive thinking, the next step is to learn how to challenge the negative thoughts (Moorey, 2000; Plotnik, 2002). Through Socratic questioning the therapist shows the patient how to change his or her thinking and this cognitive restructuring by the therapist usually brings relief in the session, but it takes longer for the patient to practise challenging thoughts outside the therapy session, which becomes a situation where the therapist models the process of cognitive restructuring and gives the patient feedback on his or her success at the task. Patients are encouraged to use a form to record and challenge their automatic thoughts to help them internalise the process of identifying and modifying negative automatic thoughts (Moorey, 2000). The therapist can use a number of methods to help a patient modify negative thinking (Moorey, 2000), such as:

Reality testing: This is probably the most common method of cognitive restructuring, where the patient is taught to question the evidence for the automatic thoughts.

Looking for alternatives: People who are in an emotional crisis, especially if diagnosed with HIV, often find it difficult to examine the options that are open to them. The therapist gently asks for alternative explanations or solutions and continues until as many as possible are generated. At first these will probably all be negative, but after a while the patient will start to come up with more constructive alternatives.

Decatastrophising: This method refers to re-evaluating and modifying catastrophic thoughts (Beck et al., 1993). It is called the “what if” technique. The patient is taught to ask what would be the worst thing that could happen. In many cases when the fear is confronted, it becomes clear that it is not so terrible after all. For example, you have been diagnosed HIV positive and are on treatment. You are preparing to visit a friend for the weekend. You have not yet disclosed your status to him/her; hence you get into more and more of a panic trying to think about how to disclose. Why would it be so awful if you failed to disclose your status? Would it be the end of the world if you failed to disclose your status and that you are on treatment?

Advantages and disadvantages: This is a very helpful technique to enable patients to get things into perspective. If a difficult decision has to be made or if it seems difficult to give up a habitual maladaptive behaviour, the patient can list the advantages and disadvantages of a certain course of action (Beck, Freeman, Pretzer, Davis, Fleming, Ottaviani, Beck, Simon, Padesky & Meyer, 1990; Moorey, 2000). For example, a patient who is dissatisfied with her job might be helped to analyse the advantages and disadvantages of the job. If the disadvantages are stronger and/or more numerous, the therapist might discuss finding a new job (Beck, 1995).

Cognitive therapy was originally designed as a treatment for individuals. It has, however, been adapted for use with groups (Rose, 1999). Most insight therapies can be conducted on either an individual or group basis (Kaplan & Sadock, 1993). The researcher will now take a look at the use and limitations of cognitive therapy.

3.2.3 The Use and Limitations of Cognitive Therapy

Cognitive therapy has proved effective in treating a variety of symptoms. Cognitive therapy was as effective as various drug therapies in treating depression, general anxiety, agoraphobia, panic attacks, stop smoking, eating disorders and reducing anger because patients showed to respond well to therapy (Beck, 1991; Beck & Fernandez, 1998; Deffenbacher, Dahlen, Lynch,

Morris & Gowensmith, 2000; Dobson & Khatri, 2000; Hollon & Beck, 1994; Plotnik, 2002). In some cases, the benefits of cognitive therapy lasted longer than those of other forms of therapy (Hollon & Beck, 1994).

The limitations of cognitive therapy are that it requires clients to have average intelligence, as intelligence plays a pivotal role in understanding the techniques that are used to make clients aware of their cognitive processes and to change their thinking patterns. Not all clients are suitable for cognitive therapy or at least some will need a highly modified form of it.

Other difficulties of cognitive therapy include recurrent difficulties in identifying or challenging thoughts. Some clients may be hesitant to say they do not understand in case they are thought to be stupid or they may not like to question the therapist as an 'authority figure' because of fear of rejection. The bedrock of cognitive therapy lies in identifying specific thoughts, relating these thoughts to emotion and other aspects of the client's being, and learning to see alternative perspectives. However, identifying and challenging thoughts is a common area of difficulty. Some clients report that they do not have, or are not aware of particular thoughts. The client may find it difficult to separate out thoughts and feelings (Wills & Sanders, 1997).

Furthermore, the client may believe that the aim of therapy is to 'think positive' and will therefore be reluctant to describe negative thoughts. Sometimes what sounds like a negative thought to challenge is more like reality, and to try and look for alternatives leaves the client feeling misunderstood or her difficulties unimportant. Another frequent difficulty is in the process of working through of therapeutic change. Therefore, in cognitive therapy, the client may find that the therapy makes intellectual sense but not result in feeling any different. If the client has felt this way for a long time, it will take time and practice to change. At other times, the client's difficulties in feeling any different are an indication that the therapist needs to move to another cognitive level. Therefore, the use of language such as challenging thoughts can produce intellectual but not emotional shift (Wills & Sanders, 1997).

According to Wills and Sanders (1997), homework is an integral part of cognitive therapy and indeed, completion of homework is linked with the success of therapy. Homework also presents some of the most common difficulties in cognitive therapy, often simply being forgotten or otherwise not completed, not understood, or itself causing the client problems.

Additionally, cognitive therapy requires thinking time for both client and therapist as it can be very demanding on the therapist's energy.

In addition, whilst we may assume that our clients want to see therapists, this may not always be the case. Therapy may arise as a result of family pressures, keeping employment, avoiding a prison sentence – in such instances the client

may not be too interested in therapy. Clients who are severely depressed may also have little motivation to attend or engage in therapy feeling too hopeless to believe that there is any point in trying to change. Whatever the difficulty in motivation, it clearly needs addressing at an early stage (Wills & Sanders, 1997).

The cornerstone of cognitive therapy is the collaborative relationship. This however, is not always easy to achieve due to the lack of both the client and therapist working together in an open manner to resolve client's difficulties, the therapist may become 'the expert' and start to offer directive advice; tasks may be set, not negotiated; the client may become 'over-compliant' or 'non-compliant'. For example 'agreeing' with the therapist on homework tasks and not carrying them out. The therapist may get the feeling of being a 'bully' teacher. In such instances, the therapist may lack empathy, or not be able to understand the client or have extreme negative or positive feelings towards the client, causing difficulties in remaining an objective collaborator (Wills & Sanders, 1997).

Another difficulty may also arise if the client and therapist do not share the same conceptualisation of the client's problems, so both are working to different agendas: the therapist may have arrived at a working conceptualisation of the client's difficulties and the client may agree in principle with the model but not believe that it applies to him/her personally. These differences can cause relationship difficulties even before therapy commences (Wills & Sanders, 1997).

Difficulties in the therapeutic relationship may reflect a mis-match between the client's needs and the therapist's style or mode of therapy. For example, Socratic questioning, which requires a high level of structure may not suit some clients, being so incompatible with their beliefs and assumptions as to make developing a therapeutic relationship extremely difficult. Whilst some clients may want therapists to be active and directive, others prefer a non-directive or a relatively inactive therapeutic style. Alternatively a less structured form of therapy, focusing on the therapeutic relationship, may be very threatening and difficult for some clients. The client's difficulties themselves may intrude on the therapeutic relationship. For example, if the client is very depressed and hopeless, the therapist needs to be more energetic and hopeful; panic clients want the therapist's help in avoiding anxiety and may therefore resent the cognitive therapist's attempts to elicit anxiety during therapy. Therefore both individual therapist and client characteristics and the characteristics of the therapy can cause difficulties (Wills & Sanders, 1997).

Cognitive therapy methods are increasingly combined with those of behaviour therapy, which is the approach discussed next. The result is a very popular approach called cognitive behaviour therapy (CBT).

3.3 BEHAVIOUR THERAPY

Behaviour therapy, which is also called behaviour modification, uses the principles of classical and operant conditioning to improve human functioning. It focuses on changing particular behaviours that are harmful to a person (Papalia & Olds, 1988; Plotnik, 2002). For example, an HIV-positive woman's maladaptive behaviour of isolating and rejecting herself due to stigma related to HIV/AIDS.

Behaviour therapy focuses on observable behaviours. The behaviour therapist identifies specific behaviours that need to be changed (for example, an HIV-positive person's anger that is directed inwardly and disturbs her functioning) and provides the patient with particular methods for carrying out the changes. For instance, mastery and pleasure ratings enable the therapist to establish the activities that might be enjoyable for the patient and to encourage the patient to engage in them with greater frequency.

Behaviour therapies require that clients' vague complaints ("my life is filled with frustration") be translated into concrete behavioural goals ("I need to learn assertive responses for dealing with colleagues"). Once the troublesome behaviours have been targeted, the therapist can design a programme to alter these behaviours. The nature of the therapeutic programme will depend on the types of problems identified (Weiten, 1995).

Behaviour therapists make no attempt to help patients achieve grand insights about themselves. If, for example, compulsive gambling troubles a patient, the behaviour therapist does not focus on whether this behaviour is rooted in unconscious conflicts or parental rejection. What is significant for the patient is that she needs to overcome that maladaptive behaviour. The therapist then designs a programme to eliminate compulsive gambling (Weiten, 2002).

Behaviour therapies involve the application of the principles of learning to direct efforts to change patients' maladaptive behaviours (Weiten, 2002). Behaviour therapy helps one to weaken the connections between troublesome situations and habitual reactions to them such as fear, depression, rage, or self-defeating or self-damaging behaviour that HIV-positive women experience due to stigma related to HIV/AIDS. It also teaches the patient how to calm his/her mind and body, so that he/she can feel better, think more clearly and make better decisions. O'Sullivan (2000) explains that a behaviour therapist's goal is to change behaviour directly.

3.3.1 General Principles

Behaviour therapies are based on a few assumptions:

- Behaviour is a product of learning. No matter how self-defeating or pathological a patient's behaviour might be, the behaviourist believes that it is the result of past conditioning (Agras & Berkowitz, 1999).
- What has been learned can be unlearned. The same learning principles that explain how the maladaptive behaviour was acquired can be used to overcome it. Behaviour therapists, thus, attempt to change patients' behaviour by applying the principles of classical and operant conditioning, and observational learning (Agras & Berkowitz, 1999).

Behaviour therapies are close cousins of the self-modification procedures as both use the same principles of learning to alter behaviour directly. Behaviour therapy, like self-modification, involves designing specific procedures such as systematic desensitisation, aversion therapy, social skills training, modelling, behaviour rehearsal and shaping, for specific types of problems (Weiten, 2002).

3.3.2 Behavioural Techniques

Behavioural techniques serve three purposes in therapy: 1) They work to change behaviour through a broad range of methods; 2) they serve as short-term interventions in the service of longer-term cognitive change, and 3) when patients are deficient in skills, therapy must include a skill-building component. The second goal differentiates the behavioural tasks used in cognitive therapy from those used in more conventional behavioural therapy. These behavioural tasks are set within a cognitive conceptualisation of the problem and are used to produce cognitive change. Seen in its simplest form, behavioural work changes cognitions by distracting patients from automatic thoughts and challenging maladaptive beliefs through experimentation. Behavioural methods are often used at the beginning of therapy when the patient is most distressed and so less able to use cognitive techniques. For example, a patient who is forever thinking about death following her HIV diagnosis could be tasked to engage in a particular activity to reduce the frequency of automatic thoughts (Beck et al., 1990; Moorey, 2000). Some techniques used are explained below:

Activity monitoring and scheduling: It is the technique whereby the therapist may ask the patient first to monitor her activities to collect relevant data. The data that this activity provides can be invaluable and subsequent changes in the patient's activities often improve her mood significantly (Beck, 1995). It can be a useful basic strategy for understanding and modifying behaviours and for increasing productive behaviours (Beck et al., 1993). It is a technique that is particularly useful with depressed patients but that can be applied with other problems too. The rationale for scheduling time centres on the proposition that when HIV-positive people are depressed, they reduce their level of activity and spend more time ruminating on negative thoughts (Moorey, 2000).

The schedule is an hour-by-hour plan of what the patient does. As with all the procedures in cognitive therapy, this need to be explained in some detail and a clear rationale should be given. It is often set up as an experiment to see if certain activities will improve the patient's mood. The therapist stresses that few people accomplish everything they plan, and the aim is not to get all the items done but to find out if planning and structuring time can be helpful. Initially the aim may just be to monitor tasks together with the thoughts and feelings that accompany them. The emphasis is usually on engaging in specific behaviours during a certain period. For instance, a patient would be encouraged to monitor her activities rather than ruminating on negative thoughts. These activity monitoring and scheduling tasks are often set up as homework assignments and the results are discussed at the beginning of the next session (Moorey, 2000).

Mastery and pleasure ratings: When patients engage in various activities, it is useful to have them record the degree of mastery and pleasure associated with a prescribed activity. The term "mastery" refers to a sense of accomplishment when performing a specific task. "Pleasure" refers to pleasant feelings associated with the activity (Beck et al., 1993). Mastery and pleasure ratings can be used in conjunction with activity scheduling. Patients rate how much mastery (feelings of success, achievement or control) or pleasure they get out of a task (on a 0-10 scale). Since HIV-positive patients often avoid engaging in pleasant activities, this method allows the therapist not only to establish which activities might be enjoyable for patients but also to encourage them to engage in them with greater frequency. It also challenges all-or-nothing thinking, by showing that there is a continuum of pleasure and mastery rather than experiences that are totally enjoyable and that yield complete success or failure (Beck et al., 1990; Moorey, 2000).

Graded task assignments: The all-or-nothing thinking can also be challenged by using graded tasks assignments. Many patients think, "I have to be able to do everything I set myself, or I have failed". The therapist begins by setting small homework tasks, which gradually build up in complexity and difficulty. The patient is encouraged to set goals that can realistically be achieved, so that he or she completes a series of successful assignments (Beck et al., 1990; Moorey, 2000). The therapist generally suggests starting with an activity that is associated with low to moderate anxiety, practising this step every day or even several times a day until the patient's anxiety has decreased significantly. The patient then attempts the next task in the hierarchy until she can do it with relative ease (Beck, 1995).

Behavioural experiments: Behavioural experiments are used to test the validity of patients' beliefs and constitute an important evaluative technique (Beck, 1995; Beck et al., 1993). Hypotheses are continually generated and put to the test. This usually involves a negative prediction of some form. For instance, an anxious patient may state that she is too anxious even to read. An experiment can be set up in the therapy session where the patient reads a short paragraph from a

newspaper, thus disproving the absolutism of this statement. The patient can then go on to read articles of increasing length over the following week. Experiments are often set as homework. For instance, a depressed patient who firmly believes that she is unable to go shopping could be asked to go shopping with her husband. Even if the patient is not able to carry out the assignment, the experiment is not a failure because it provides valuable information about what might be the obstacles to the activity (Moorey, 2000).

Relaxation: Several methods of relaxation training can be used successfully – graded muscle relaxation, breathe control, visualisation of pleasant scenes, meditation, and so on. These can be taught in the session, or the patient can take along a relaxation tape. Relaxation serves the following purposes in therapy:

- Promoting self-awareness and monitoring of bodily states
- Providing a coping technique for reducing anxiety
- Providing a coping technique to facilitate the execution of behavioural experiments
- Promoting a feeling of mastery over symptoms (Moorey, 2000; Weiten, 2002).

Relaxation training may be a useful technique in that it provides the patient with a safe method of relaxing. Ultimately, relaxation training may be useful in building the patient's new belief that she is in control of and responsible for her coping responses (Beck et al., 1993).

Behavioural rehearsal: This type of technique is used frequently during the session in preparation for a difficult homework assignment (Beck et al., 1990; Moorey, 2000). It involves the practise of that given task which is performed as a trial during the therapy session.

Role-play: This can be a very effective cognitive change technique. When patients have practical problems that need to be solved, behavioural techniques based on a skills training model are especially useful. This will usually involve forms of assertiveness training or social skills training for people who lack interpersonal skills (Moorey, 2000; Weiten, 2002). Role-play involves the therapist explaining and demonstrating to the client a behavioural technique such as assertiveness and the therapist allowing the client to role-play that skill. Role-playing can be used to uncover automatic thoughts, to develop a rational response, and to modify intermediate and core beliefs (Beck, 1995).

In vivo exposure: This technique involves arranging for the therapist to go with the patient to a problematic setting, so that the therapist can help the patient deal with dysfunctional schemas and actions that could not be detected in the ordinary consultation setting (Beck et al., 1990).

Use of imagery: This method can be used to enable the patient to “relive” past traumatic events and thus to restructure the experience and consequently the derivative attitudes. The rationale for this procedure requires some consideration: simply talking about a traumatic event may, for instance, give intellectual insight about why the patient has a negative self-image, but it does not actually change the image. In order to modify the image, it is necessary to go back in time, as it were, and recreate the situation. When the interactions are brought to life, the misconception is activated – along with the affect – and cognitive restructuring can occur (Beck et al., 1990). The researcher will next evaluate the value of behaviour therapy.

3.3.3 Evaluating Behaviour Therapies

It may be misleading to make global statements about the effectiveness of behaviour therapies, because they include many procedures designed for different purposes. The value of aversion therapy for sexual deviance, for example, has no bearing on the value of systematic desensitisation for phobias (Lambert & Bergin, 1992).

Behaviour therapies can impact significantly on the treatment of various conditions such as obsessive-compulsive disorders, phobias, drug-related problems, sexual dysfunction, schizophrenia, psychosomatic disorders, eating disorders, autism, hyperactivity and mental retardation. Such therapies are effective because they relieve a variety of psychological and behavioural symptoms, and focus on observable behaviours (Agras & Berkowitz, 1999; Emmelkamp, 1994; Papalia & Olds, 1988; Wisner et al., 1996). Behaviour therapies are not suited for the treatment of certain types of problems, for example, problems caused by past psychic conflicts as it deals with the current behaviour only.

Primary limitations for behavioural treatment include: 1) A shortage of trained specialists; 2) cost and variable insurance reimbursement, and 3) the assumption that medications are more efficacious (Smith, Perlis, Park, Smith, Pennington, Giles & Buysse, 2002). In a study of a comparative meta-analysis of pharmacotherapy and behaviour therapy for persistent insomnia conducted by Smith et al. (2002), it was established that behavioural interventions are not particularly efficacious in increasing total sleep time in the short-term.

Behaviour therapy is often criticised as it concentrates more on behaviour itself and less on the presumed underlying cause. Psychodynamic approaches predict that removing a symptom while ignoring the underlying cause will result in either the recurrence of that symptom or the appearance of a substitute symptom. Behaviour therapy concentrates on the present whilst clients beginning therapy often expect that they will be asked to delve into their early childhood experiences in minute detail. In fact, psychoanalytic and related approaches do strongly emphasise the importance of uncovering early events assumed to be

critical. Psychoanalytic theory holds that a client's insight into these experiences is of curative value (Masters, Burish, Hollon & Rimm, 1987).

The next therapy to be discussed is a combination of behaviour and cognitive therapy, which was actually used in this study to facilitate behaviour change.

3.4 COGNITIVE BEHAVIOUR THERAPY (CBT)

CBT combines two very effective kinds of psychotherapy, namely cognitive and behaviour therapy (Bea & Tesar, 2002; Bush, 2003; Möller & Van Tonder, 1999; Wisner et al., 1996). CBT has become a leading psychotherapy in most parts of the world, partly due to the close link between science and practice characteristic of the movement, and the demonstrated effectiveness of the treatment (Möller & Van Tonder, 1999). Cognitive and behaviour therapies provide very powerful tools for stopping symptoms and getting one's life on a more satisfying track. In CBT, the therapist takes an active part in solving the client's difficulties. The therapist does not settle for just nodding wisely while the client carry the whole burden of finding the answers he or she came to therapy for. The client receives a thorough diagnostic workup at the beginning of treatment – to make sure that the client's needs and problems have been pinpointed as well as possible. This crucial step – which is often, omitted altogether in traditional kinds of therapy – results in an explicit, understandable and flexible treatment plan that accurately reflects the client's individual needs. CBT has shown in many ways to resemble education, coaching or tutoring. Under the expert guidance, a client will share in setting treatment goals and in deciding which techniques work well for the client personally (Bush, 2003).

CBT provides clear structure and focus to treatment. Unlike therapies that easily drift off into interesting but unproductive side trips, CBT sticks to the point and changes course only when there are sound reasons for doing so. A CBT client will take on valuable "homework" projects to speed progress in therapy. These homework assignments – which are developed as much as possible with the client's own active participation – extend and multiply the results of the work done in therapy. The client may also receive take-home readings and other materials tailored to the client's own individual needs to help the person continue to forge ahead between sessions (Bush, 2003).

Most clients coming for therapy need to change something in their lives – whether it's the way they feel, the way they act or how other people treat them, for example, being discriminated against now that a person is living with HIV/AIDS. CBT focuses on finding out what needs to be changed and what doesn't – and then works for those targeted changes. Some exploration of people's life histories is necessary and desirable – if their current problems are closely tied to "unfinished emotional business" from the past, or if they grow out of a repeating pattern of difficulty. Focusing on the past (and on dreams) can at times assist to explain a client's difficulties. But these activities all too often do

little to actually overcome them. Instead, CBT aims at rapid improvement in the person's feelings and moods, and early changes in any self-defeating behaviour the client may be caught up in. In other words, CBT is more present-centered and forward-looking than traditional therapies (Bush, 2003).

The two most powerful levers of constructive change (apart from medication in some cases) are:

- 1) Altering ways of thinking – a person's thoughts, feelings, ideas, attitudes, assumptions, mental imagery and ways of directing the client's attention – for the better. This is the cognitive aspect of CBT.
- 2) Assisting a client greets the challenges and opportunities with a clear and calm mind – and then taking actions that are likely to have desirable results. This is the behavioural aspect of CBT.

In other words, CBT focuses on exactly what traditional therapies tend to leave out, that is, how to achieve beneficial change, as opposed to mere explanation or "insight" (Bush, 2003; Moorey, 2000). CBT seeks in a variety of ways to produce cognitive change – change in the patient's thinking and belief system – in order to bring about emotional and behavioural change (Beck, 1995).

CBT is built on three fundamental propositions, namely:

- 1) Cognitive activity affects behaviour.
- 2) Cognitive activity may be monitored and altered.
- 3) Desired behaviour change may be affected through cognitive change.

The term "CBT" encompasses treatments that attempt to change overt behaviour by altering thoughts, interpretations, assumptions and strategies of responding (Dobson & Block, 1988).

CBT involves the application of principles of learning. The therapist focuses on the patient's problem, identifies specific thoughts and behaviours that need to be changed, and provides techniques based on learning principles to make desired changes (Plotnik, 2002). For example, the therapist may turn toward uncovering the belief system of an HIV-positive woman that results in her anger and hurt (that is, perhaps her belief that the rejection means she is worthless). The goal of CBT would be to challenge this underlying belief about herself, in order to alleviate her anger and hurt.

The major difference between cognitive and behaviour therapy is that behaviour therapy focuses on identifying and changing specific behaviour, while cognitive therapy focuses on identifying and changing specific maladaptive thought patterns with the goal of changing behaviour (O'Sullivan, 2000; Wilson, Hayes & Gifford, 1997). Cognitive techniques address beliefs and automatic thoughts,

while behavioural techniques focus on the actions that casually interact with cognitive processes (Beck et al., 1993). CBT combines the cognitive therapy techniques of changing negative, unhealthy or distorted thought patterns with the behaviour therapy technique of changing maladaptive or disruptive behaviours by learning and practising new skills to improve functioning (Bea & Tesar, 2002; Plotnik, 2002; Wiser et al., 1996).

CBT stresses the identification of distortions in thinking, shows patients how such distortions contribute to their distress and helps them to replace these with more accurate appraisals and interpretations of reality. Cognitive therapists use some behavioural techniques and also stress internal understanding (Bea & Tesar, 2002; Papalia & Olds, 1988; Salkovskis, 1996).

The goals of cognitive therapy are to relieve symptoms and to resolve problems; to help the patient to acquire coping strategies; to correct faulty information processing to help patients modify assumptions that maintain maladaptive behaviours and emotions; and to help the patient to modify underlying cognitive structures in order to prevent relapse (Bea & Tesar, 2002; Beck & Weishaar, 1989; Clark & Steer, 1996; Hollon et al., 1996; Moorey, 2000).

Much of our behaviour is either learned or modified by learning (O'Sullivan, 2000; Skinner, 1987; Wiser et al., 1996). Cognitive therapy initially addresses symptom relief, including problem behaviours and distortions in logic, but its ultimate goal is to remove systematic biases in thinking (Allison & Denman, 2001; Beck & Weishaar, 1989).

Cognitive change can promote behavioural change by allowing the patient to take risks. In turn, experience in applying new behaviours can validate new perspectives. Considering evidence and facts by enlarging perspectives to include alternative interpretations of events can moderate emotions. Emotions play a role in cognitive change, for learning is enhanced when emotions are triggered. Thus, the cognitive behavioural and emotional channels interact in therapeutic change, but cognitive therapy emphasises the primacy of cognition in promoting and maintaining therapeutic change (Bea & Tesar, 2002; Beck & Weishaar, 1989; Wiser et al., 1996).

Through both cognitive and behavioural methods, the patient discovers more adaptive ways of thinking and behaving. The patient learns how to correct faulty cognitive processing so that it is eventually no longer necessary to depend on a therapist (Bea & Tesar, 2002; Beck & Weishaar, 1989; Kelly, 1987; Moorey, 2000; Wilson, 1989; Wiser et al., 1996).

Cognitive therapy maintains that the modification of dysfunctional assumptions leads to effective cognitive, emotional and behavioural change. Patients change by recognising automatic thoughts, questioning the evidence used to support them and modifying cognitions to more closely fit the available data. Next, the

patient behaves in ways congruent with new, more adaptive ways of thinking. Thus, the patient experiences a new way of processing information and the consequences stemming from it (Bea & Tesar, 2002; Beck & Weishaar, 1989; Clark & Steer, 1996; Hollon et al., 1996; Wiser et al., 1996).

Cognitive therapy employs behavioural methods, which are designed to challenge specific maladaptive beliefs (for example, being HIV positive might mean that one is worthless) and to promote new learning. Behavioural techniques are also used to expand patients' response repertoires (Bea & Tesar, 2002; Beck & Weishaar, 1989; Plotnik, 2002; Wilson, 1989; Wiser et al., 1996). In this study, the researcher assisted HIV-positive women to change and challenge their dysfunctional beliefs about their experience of internalised stigma and discrimination, and to promote more realistic adaptive ways of thinking, as described in later chapters. These changes are significant as HIV/AIDS-related stigma negatively affects all aspects of HIV prevention, diagnosis, treatment and care (Bond et al., 2002).

CBT is usually brief and most clients are able to complete their treatment in a few weeks or months – even for problems that traditional therapies often take years to resolve, or aren't able to resolve at all. Meanwhile, for the clients with complex problems, or who are forced to live in adverse conditions beyond their control, longer-term treatment is also available. The length of therapy depends on the client's needs and the way the CBT therapist prefers to work. As a rule, however, most clients can expect to begin their treatment with weekly visits. A few of the clients – particularly those in crisis – may begin with two or more sessions a week until their condition is stabilised enough that they can safely come only once a week (Bush, 2003). The researcher will now take a look at the use and disadvantages of CBT.

3.4.1 The Use and Limitations of Cognitive Behaviour Therapy

CBT has been shown to be effective as drugs in treating both depression and anxiety. CBT has been shown to be better than drugs in avoiding treatment failures and in preventing relapse after the end of treatment. Other symptoms for which CBT has demonstrated its effectiveness include mood swings; problems with establishing or staying in relationships; problems with marriage or other relationships an individual is already in; work, career or school difficulties; insomnia and other sleep problems; insufficient self-esteem; obsessions and compulsions; substance abuse; trouble keeping feelings such as anger, sadness, fear, guilt, shame, eagerness, excitement and so on, within bounds. CBT is usually the preferred treatment for shyness, headaches, panic attacks, phobias, posttraumatic stress, eating disorders and obesity, loneliness and procrastinations (Bush, 2003).

The disadvantages of CBT are that it requires patients to participate actively in their own treatment by monitoring themselves and doing homework. Patients

who are unmotivated, suffering from inertia caused by depression or otherwise resistant may not be able to exert the required energy. CBT also requires therapists to be robust in their efforts and energy. Psychodynamic theorists criticise CBT for neglecting underlying psychic conflict and other critics suggest that patients may experience symptom substitution, that is, manifest new symptoms after suppressing old ones (Bea & Tesar, 2002). As a long standing clinical treatment for adult disorders, nevertheless, CBT has come under some recent challenges. For instance, Graham and Parker (2000) suggest that it has high “treatment principle credibility” for both clients and practitioners but that its benefits are not necessarily derived from treatment-specific factors – how then does it hold up for children when, for instance children may not be matured enough to undergo CBT in the same way as adults.

A criticism sometimes directed at CBT is that, compared to other approaches it focuses on cognitions to the exclusion of feelings. Emotion clearly is a crucial part of a client and an important focus for change (Epstein, Schlesinger & Dryden, 1988).

Limited intellectual capacity may impede the learning process during therapy. The limited ability for abstract thought may interfere with a client’s ability to grasp and apply techniques whose effectiveness relies on accurate recognition of cues to trigger their application. Difficulty thinking abstractly may impede this crucial process and limit the effectiveness of CBT techniques, whether the difficulty is related to low intellectual capacity or to rigid thought processes among intellectually endowed individuals (Epstein, Schlesinger & Dryden, 1988).

The researcher will next describe a guideline of the intervention model used in this research.

3.5 A GUIDELINE OF THE INTERVENTION MODEL

Beck's original cognitive model of depression and mania was used as a guideline in this study. This model suggests that depressed mood states are accentuated by patterns of thinking that amplify mood shifts. For example, as people become depressed they become more negative in how they see themselves, their world and their future (called the “negative cognitive triad”). Hence they tend to jump to negative conclusions, over-generalise, see things in all-or-nothing terms, and blame themselves to an excessive degree (cognitive distortions). Changes in behaviour, such as avoidance of social interaction, may be a cause or a consequence of mood shifts and negative thinking. Cognitive vulnerability is thought to arise as a consequence of dysfunctional underlying beliefs (for example, “I am unlovable”), which develop from early learning experiences, and drive thinking and behaviour. It is hypothesised that these beliefs may be activated by life events that have a specific meaning for that individual (for

example, rejection by a significant other) (Beck et al., 1993; Clark & Steer, 1996; Scott, 2001; Wiser et al., 1996).

Cognitive therapy is directed towards alleviating specific cognitive biases and distortions, developing behavioural skills, reducing environmental stress, developing support, and assisting patients to communicate their concerns to others more clearly and adaptively (Reinecke, 1994). Cognitive therapy is based on the cognitive model, which hypothesises that people's emotions and behaviours are influenced by their perception of events (Beck, 1995). Using this theoretical framework, an intervention model was suggested to be used with the HIV-positive women in therapy to address themes in dealing with the experience of internalised stigma and discrimination.

The goals of therapy are to assist the women to cope with stigma by initiating a relationship with them, to elicit essential information, to produce some symptom relief and to instil hope (Bea & Tesar, 2002). Symptom relief make the patient feel better immediately and provide her with evidence that the CBT model works well, and so help to build a treatment alliance (Allison & Denman, 2001).

Building a relationship with the patient begins with questions about feelings and thoughts about commencing with therapy. Discussing the patient's expectations helps to put the patient at ease, provides information to the researcher regarding the patient's expectations and presents an opportunity to demonstrate the relationship between cognition and affect.

The participants will be familiarised with CBT since the researcher will actively intervene to provide symptom relief. As therapy progresses, the different cognitive misconceptions that will be frequently used will be addressed one by one.

In the next chapter the researcher will describe the research methods used to identify the most important cognitive distortions of women addressed in therapy and the development and implementation of the intervention model. The implementation process and outcome of the therapeutic process will be assessed as part of this research.

CHAPTER 4

RESEARCH METHODS

4.1 INTRODUCTION

In this section, the researcher discussed the procedure that he followed in developing an intervention model (Phase 1) and how he assessed the model's effectiveness in helping women to deal with stigma related to HIV. In order to enable the reader to understand the research, the following topics will be discussed:

- Qualitative and quantitative methods
- Research design
 - Phases of research
 - Goal of the study
 - Focus group with the researcher's colleagues
 - Sampling
 - Data-gathering instruments and interviews
 - Ethical considerations
 - Data analysis
- Accuracy and reliability of data
- The researcher's role

4.2 QUALITATIVE AND QUANTITATIVE METHODS

Data to be collected are either qualitative data, which are expressed in words and give evidence of meaning and significance, or quantitative data, which are expressed in numbers and give a summation of frequency. Qualitative data include observations, conversations, anecdotes, letters and diaries. These sources are often very rich in insights and provide a background against which a participant is greatly enlightened (Neuman, 2000; True, 1989).

Quantitative data consist of counted items. They can only represent the presence or absence of something that can be counted or the dimensions of something that can be measured (Denzin & Lincoln, 2000; Henning, Van Rensburg & Smit, 2004; Hopkins, 2000; Kelle, 2001; Neuman, 2000; Ruane, 2005). Sometimes this is essential. People who focus too much on the quantitative (cost) and neglect the qualitative (happiness) are sometimes criticised. The ideal research project includes both (True, 1989).

A quantitative approach may be described in general terms as that approach to research in the social sciences that is highly formalised. In addition, it is more explicitly controlled with a range that is more exactly defined, and which in terms of the methods used, is relatively close to the physical sciences. In contrast, qualitative approaches are those approaches in which the procedures are not as strictly formalised, while the scope is more likely to be undefined and a more philosophical mode of operation is adopted (De Vos, 2002b; Mouton & Marais, 1990).

The requisite skills for doing qualitative research are to step back and critically analyse situations, to recognise and avoid bias, to obtain valid and reliable data and to think abstractly. To do these, a qualitative researcher requires theoretical and social sensitivity, an ability to maintain an analytical distance while at the same time drawing upon past experience and theoretical knowledge to interpret what is seen, astute powers of observation and good interactional skills (Strauss & Corbin, 1990).

Qualitative investigation methods are used to investigate the nature of social phenomena (Maso, 1989). Qualitative research gives an accurate description and if possible, explanations of what are empirically found about the phenomenon. Morrall (1994) also adds that qualitative research is flexible and that it attempts to understand people from their own frame of reference.

Qualitative research helps the researcher to understand participants through the use of in-depth semi-structured and unstructured interviews. These in-depth interviews are used where subjective human experience is the key focus, exploring individuals in particular contexts, to determine issues for future research and to probe into complex processes (Mouton & Marais, 1990). In this instance, the researcher assessed and recommended an intervention model for women living with HIV/AIDS to assist them in dealing with the experience of internalised stigma and discrimination identified by means of in-depth interviews.

One major feature about well-collected qualitative data is that they focus on naturally occurring, ordinary events in natural settings, so that there is a strong understanding of what "real life" is like (Miles & Huberman, 1994). Qualitative data provide depth and details through direct quotation and careful description of events, people, interactions and observed behaviours (Patton, 1997). The major advantages of qualitative methods are that:

- 1) They enable researchers to study human experience in a great deal of depth
- 2) The methods stay closer to the experience of participants and researchers and
- 3) People who read the research report can obtain a deeper and more human understanding of what has been discovered (Louw & Edwards, 1998).

Quantitative methods, on the other hand, use standardised measures that fit diverse opinions and experiences into predetermined response categories. The

advantage of quantitative approaches is that they measure the reactions of a great many people to a limited set of questions, thus facilitating comparison and statistical aggregation of the data. This gives a broad, generalisable set of findings (Patton, 1997).

Quantitative methods provide a basis for comparing one result with another. The other advantage is that numbers can be subjected to mathematical procedures and worked with on a computer, so they provide ways to deal with large bodies of data. In addition to their advantage is the fact that statistical techniques permit hypotheses to be rigorously tested (Louw & Edwards, 1998). By contrast, qualitative methods typically produce a wealth of detailed data about a much smaller number of people and cases (Patton, 1997). The aim of quantitative research is to determine how a variable affects another variable in a population. It calls for procedures that use precise definitions that use objectivity-seeking methods of data collection and analysis that is replicable so that findings can be confirmed or disconfirmed, and that are systematic and accumulative (Denzin & Lincoln, 1994).

Merging quantitative and qualitative data analyses provides important clues for explaining the processes of continuity and change in human behaviour in the course of life. Both qualitative and quantitative data are essential for understanding the role of historical context in individual development over time. Therefore, qualitative and quantitative data about individual lives and social structures can be integrated to fully understand stability and change in behaviour over time (Laub & Sampson, 1998). Qualitative and quantitative methods have often been used together in the same research project and in many cases such integration has resulted in enlightened insights about the investigated social phenomena and provided complementary findings (Allan, 1991; Kelle, 2001).

The use of multi-methods allows the researcher to get a perspective of multiple understandings of the reality as emphasised in post-modernistic thought. Post-modernistic thought emphasises the importance of multiple understandings of reality. The overall approach to the study can therefore be viewed as a multi-method approach, which involves the combination of qualitative and quantitative methods. Multi-method research takes three forms, which include triangulation, facilitation and complementary research (Seedat, Duncan & Lazarus, 2001). The two set of data were used to complement each other, as they provide different viewpoints of the research. This is a strategy for improving the validity and reliability of research findings. Both qualitative and quantitative methods were regarded as suitable in this research as they allowed the researcher to compare the current research with the research of other people. The other advantages of combining both these types of research include the following:

- Research development where one approach is used to inform the other such as using qualitative research to develop an instrument to be used in quantitative research.

- Increased validity where results obtained through one method can be confirmed by means of different data sources.
- Complementarily adding information, that is, words to numbers and vice versa.
- Opportunities for further research that can be attained by creating new lines of thinking by the emergence of fresh perspectives or contradictions (Casebeer & Verhoef, 1997).

4.3 RESEARCH DESIGN

The current research was conducted in two phases.

4.3.1 Phases of the Research

In Phase 1, data was obtained about HIV-positive women in order to be used in the development of an intervention model.

Phase 2 focused on the implementation and evaluation of the therapeutic model that was used with ten HIV-positive women who served as the experimental group and ten women who constituted the control group. The two phases will be discussed in detail below.

Phase 1: Development of an Intervention Model

The first phase of the research was used to gain an understanding of the women's experiences of HIV-related stigma and discrimination to be able to develop an intervention model. The following sources of information were used to identify the relevant themes that had contributed to the individual's experience of felt stigma and ways to change it:

- Study of the available literature

The literature was used to identify themes to be dealt with in therapy (see Chapter 2).

- Researcher's own experience

The researcher used the experience that he had gathered over nine years as a clinical psychologist, where he worked in hospitals and private practice in Mpumalanga with HIV-positive women struggling to deal with internalised stigma and discrimination. As there was hardly any documented literature available to help practicing psychologists to assist HIV-positive women to cope with stigma, the need for a CBT model was evident.

- Focus group discussions with colleagues

Focus group discussions were held with colleagues who work with HIV-positive women. The aim was to gather valuable information from them about the cognitive themes that influence HIV-positive women's experiences,

women's coping skills and strategies they use in assisting HIV-positive women to cope with stigma.

- Interviews with HIV-positive women

Interviews in the form of case studies were conducted with HIV-positive women. In Phase 1 in-depth interviews were conducted with five HIV-positive women to gather themes to be addressed in therapy.

- Psychometric scales used on HIV-positive women

Five psychometric scales were used to assess women's experiences of HIV-related stigma and discrimination and to assess the applicability of these scales in this population.

4.3.2 Focus Group Discussions with Colleagues

In this study, one focus group discussion was conducted with three colleagues (clinical psychologists) who work with HIV-positive women. Five colleagues had initially been approached to participate and had agreed to come. Unfortunately only three (two females and a male) eventually showed up. These three have worked as clinical psychologists for a period of seven years each and are currently practicing at Soweto clinics, the Louis Pasteur Hospital and Sebokeng clinics respectively. The two colleagues who did not turn up on the day have been working as clinical psychologists at the Dr George Mukhari Hospital for a period of eleven years each. (It must be noted that it was only when the latter two did not show up for the third time that the researcher decided to proceed with the available three colleagues.)

A focus group works with value-generated information gained from social discussions and social influence. It is also defined as a research technique that collects data through group interaction on a topic determined by the researcher (Greeff, 2002). Focus group research is among the most common research methods used to gather information. A focus group discussion involves a group discussion of a topic that is the "focus" of the conversation.

All of the five colleagues who had been invited to the focus group discussion were deliberately chosen on the basis of their experience of CBT, their work with HIV-positive women and their willingness to participate in this study. The current focus group interview consequently involved colleagues who discussed questions posed by a researcher, with the goal of wanting to know about themes to be addressed in therapy (see Appendix A), ways in which HIV-positive women cope with internalised stigma and discrimination, and the therapeutic techniques that they use to assist the women to cope. These topics were discussed under the direction of the researcher, who facilitated the discussion by allowing each person a chance to participate in the discussion. Interaction was promoted, and care was taken to assure that the discussion remained on the topic of interest (Greeff, 2002). In this research, the focus group discussion with colleagues continued for an hour and half. The researcher greatly influenced the flow of the

conversation and therefore also the group dynamics and the manner in which the group narrative took place (Hesse-Biber & Leavy, 2006).

The most common purpose of a focus group interview is to stimulate an in-depth exploration of a topic about which little is known (Fowler, 1998; Stewart & Shamdasani, 1998). Focus groups have become an important technique because they offer a way for researchers to obtain different views from diverse people in a discussion (Madriz, 2000). It is a method of qualitative interview where multiple respondents are interviewed simultaneously but encouraging interaction to stimulate discussion (Hesse-Biber & Leavy, 2006).

Focus groups, along with a few other techniques such as unstructured individual in-depth interviews, provide data that are close to the emic (data that arise in a natural or indigenous form) range. They allow individuals to respond in their own words using their own categorisations and perceived associations. They are not completely void of structure, however, because the researcher does raise questions of some type or other (Stewart & Shamdasani, 1998).

The researcher conducted the focus group in English and Setswana as those are the spoken languages of the researcher's colleagues. Thereafter the discussion was transcribed and translated with the assistance of two educators who are teaching English and Setswana at school, who are fluent both in Setswana and English. In the interpretation of the data the researcher was assisted by a male colleague who has been a clinical psychologist for a period of seven years and currently works with HIV-positive women at the Louis Pasteur Hospital. This was done in order to obviate biases and differences. Wherever there were differences, consensus was reached after discussion of themes. Data was analysed qualitatively using Rubin and Rubin's (1995) method (described in Section 4.3.5).

4.3.3 Interviews with HIV-positive Women

Five case studies of HIV-positive women were conducted in this phase of the study to develop an understanding of how they experience HIV and how they cope with the illness and the stigma. According to Stake (1994; 2000) and Kazdin (1980), case studies can generate new knowledge and methods that are valuable because they suggest new applications for a given therapeutic technique. The case study's unique strength is its ability to deal with a large variety of evidence such as data gathered through interviews and observations (Yin, 1985). A case study design is employed to gain an in-depth understanding of the situation and what it means for those involved (Henning, Van Rensburg & Smit, 2004).

4.3.3.1 Sampling

A purposive sampling technique was used for this study. In purposive sampling a particular case is chosen because it illustrates some feature or process that is of interest for a particular study (Neuman, 2000; Strydom & Delpont, 2002; Strydom & Venter, 2002). This technique enabled the researcher to assess and recommend an intervention model for women living with HIV/AIDS.

The sample consisted of five black South African women who were living with HIV/AIDS and experiencing difficulties in dealing with stigma. They had been referred to the researcher by the Wellness Clinic nurses at the Witbank Hospital. The women were in their early to middle adulthood (aged 22 to 40) and were interviewed at the Witbank Hospital where they were receiving treatment. All of them were willing to participate voluntarily and had been living with HIV for at least three months or more from the time of diagnosis. They spoke at least one of the following languages fluently: Nguni, Sotho or English. All of the participants had at least passed Grade 10 and were coming from a poor to average socio-economic background (household income of up to R6000 per month). Their CD4+ lymphocyte count was below 200 per ml at the time of the study.

The case studies involved gathering detailed information. This included a comprehensive case history and a detailed account of the woman's experiences relevant to the issue that had made her a person of particular research interest because of HIV related stigma (Coolican, 1994).

4.3.3.2 Data collection methods

- **Interviews**

An interview is described as “a conversation with a purpose” (Marshall & Rossman, 1995: 80). Most important about interviews is that it permits probing into the context and reasons for answers to questions (Kerlinger, 1986).

Taylor and Bogdan (1984:77) state that “by in-depth qualitative interviewing we mean repeated face-to-face encounters between the researcher and the informants – directed towards understanding informants’ perspectives on their lives, experiences or situations as expressed in their own words”. This means that there is a specific form of interaction in which knowledge evolves through a dialogue (Kvale, 1996). The participants are requested to describe the topic being investigated in detail (Polkinghorne, 1989). As the researcher becomes aware of the meanings, questions are asked and clarifications are sought. An interview is therefore also seen as interwoven “dances” of questions and answers in which the researcher follows as well as leads (Ely, Anzul, Friedman, Garner & McCormack Steinmetz, 1991).

The interview method enabled the researcher to study the data as it emerged and not according to pre-selected aspects; thus it was used as a method of data collection (Lee, 1993). The interviews were used to gather descriptions of the experiences of women living with HIV.

Interviews were conducted with the participants at the Witbank Hospital in a private quiet office. The place where the interviews were conducted provided enough privacy for the participants to answer questions freely (Van Kammen & Stouthamer-Loeber, 1998). All interviews conducted with participants were tape recorded. A tape recorder allows a much fuller record than notes taken during the interview (Greeff, 2002).

The data-gathering instruments that the researcher used were structured and semi-structured interviews. Semi-structured interviews allowed the use of a list of questions (see Appendix A) as a guide that allowed the researcher to grasp more fully the participant's experience (Greeff, 2002; Henning et al., 2004; Kruger, 1988). Interviews were initiated in a client-centred manner, and this was followed by open-ended questions. The interpretation of data enabled the researcher to assess and recommend an intervention model by using a cognitive behavioural method for changing the experience of internalised stigma and discrimination by women living with HIV/AIDS.

- **Psychometric instruments**

The instruments discussed below were used in Phase 1 to understand the reactions of the women. The same instruments were again used in Phase 2 to evaluate change.

The Brief Cope Scale (Carver, 1997) was used to determine the coping responses of participants. There is a widely held conviction that the way in which people cope with the demands of a stressful event makes a difference to how they feel emotionally. Yet, despite this conviction, there is little understanding about the ways in which coping processes actually affect the emotion response (Folkman & Lazarus, 1988).

Historically, coping has been viewed as a response to emotion. Within the animal model of stress, for example, coping is defined as learned behaviours that contribute to survival in the face of life-threatening dangers. These behaviours are initiated by fear, which motivates the behavioural response of avoidance or escape, and by anger, which motivates attack or confrontation. Within the ego-psychology model, coping includes cognitive processes such as denial, repression and intellectualisation, as well as problem-solving behaviours that are invoked to reduce or manage anxiety and other distressing states of emotion (Folkman & Lazarus, 1988).

Much of the research on the relationship between emotion and coping in humans has focused on the ways in which emotion – in the form of anxiety – can interfere with cognitive functioning (coping). People use not only approach-avoidance behaviour or defensive processes to cope with the complex demands and constraints of a given stressful encounter, but also a wide range of cognitive and behavioural strategies that have both problem-solving and emotion-regulating functions (Folkman & Lazarus, 1988).

Theoretical models emphasise a unidirectional casual pattern in which emotion affects coping both by motivating it and impeding it. However, the relationship between emotion and coping in stressful encounters is bidirectional, with each affecting the other. The behavioural flow begins with a transaction that is appraised as harmful, beneficial, threatening or challenging. The appraisal process generates emotion. The appraisal and its attendant emotions influence coping processes, which in turn change the person-environment relationship. The altered person-environment relationship is reappraised and the reappraisal leads to a change in emotion quality and intensity. Viewed in this way, coping is a mediator of the emotion response (Folkman & Lazarus, 1988).

The Brief Cope Scale has been used in a number of health-related studies. The available evidence suggests that many of the coping responses that it assesses are important in the coping process and some are predictive of prospective physiological effects. The Brief Cope Scale consists of 14 scales containing two items each (see Appendix B). Response options range from 0 (I haven't been doing this at all) to 3 (I've been doing this a lot). The items can also be converted to a dispositional "coping style" format or a situational concurrent format, by changing verb forms (Carver, 1997). Despite the fact that the scales are only two items each, their reliabilities all meet or exceed the value of 0.50, which is regarded as minimally acceptable (Nunnally, 1978). Indeed all exceed 0.60 except for the venting, denial and acceptance sub-scales. This reliability is based on a sample of 168 participants recruited from the community that had been seriously affected by the hurricane, of which the participants were primarily non-Hispanic whites (40%), African Americans (34%), Hispanics (17%) and Asians (5%). These data are thus supportive of the internal reliability of the abbreviated scales (Carver, 1997). The reliability of the Brief Cope Scale for a sample of 317 HIV-positive women in South Africa is 0.63 for the scale as a whole; 0.75 for positive coping; 0.54 for negative coping (Makin, Forsyth, Visser, Sikkema, Neufeld, De Villiers, & Jeffery, in press). This scale was therefore also found to be applicable to use in a community of HIV-positive women.

Internalised stigma is assessed using a scale developed and adapted from the questionnaire of Westbrook and Bauman (1996) for use in South African samples (Visser et al., 2008). The scale consists of 16 questions (see Appendix C), which focus on the person's own experience of stigma (such as "I feel ashamed that I have HIV"). In a factor analysis of the scale done with the data of 317 HIV-positive women, two factors were identified: a tendency to self-blame and

interpersonal distance. The participants indicated their level of agreement with each item on a 4-point Likert-type scale (strongly agree, agree, disagree and strongly disagree). A total score of the scale is calculated in such a way that a high score means the experience of high levels of stigma (Visser & Makin, 2004). The Cronbach alpha coefficient of the internalised stigma scale was found to be 0.72 for the South African sample (Makin et al., in press), which is seen as an appropriate reliability.

Enacted stigma is the real experience of discrimination. It is assessed by 11 types of behaviour that could be discriminative in interpersonal relationships, such as avoiding interaction, ending a relationship; forms of verbal and physical abuse (see Appendix D). The questions were answered on a 3-point scale (no experience, experienced and a lot of experience). A scale score can be calculated (Visser & Makin, 2004).

The Rosenberg Self-Esteem Scale (RSES) is a widely used self-esteem measure that was created by Rosenberg in 1979. The scale consists of 10 questions (see Appendix E). The items are phrased positively, such as “I feel I have a number of good qualities” and negatively, such as “I think I am not good at all”. Participants indicate their level of agreement on a 4-point Likert-type scale (strongly agree, agree, disagree and strongly disagree). Participants receive a score ranging from 0 to 3 depending on their answer for each question and then obtain a total score ranging from 0 to 30, with 30 indicating the maximum score (Adkins, 2003). The lower the score a participant receives, the better his/her self-esteem, and vice versa. A test-retest reliability of 0.75 has been reported for a South African sample of 317 HIV-positive women (Makin et al., in press). Validity has been supported by evidence that those with low self-esteem scores appear depressed, they report feelings of discouragement and unhappiness, and they feel others have little respect for them. A high degree of convergent validity was reported when the RSES was correlated with other measures of self-esteem (Adkins, 2003).

The Beck Depression Inventory-II (BDI-II) Scale has been used in hundreds of outcome studies to monitor depression in patients (Beck, Steer & Garbin, 1988; Beck & Weishaar, 1989). BDI-II is the most widely used and best validated rating scale for the assessment of depression in clinical and normal populations (Beck & Weishaar, 1989). The BDI-II addresses all nine of the symptom criteria listed for a major depressive episode in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (4th ed. DSM-IV,1994). This scale consists of 21 groups of statements that assess the severity of depressive symptomatology (Beck, Steer & Brown, 1996). The participant is requested to pick out one statement in each group that best describes the way the participant has been feeling the past two weeks, including on that day. The participant is requested to circle the number beside the statement she has picked about her level of sadness, pessimism, past failures and so on (see Appendix F). If several statements in the group seem to apply equally well, the participant

should circle the highest number for that group. The BDI-II scale is scored by summing the ratings for the 21 items, each item rated on a 4-point scale ranging from 0 (normal) to 3 (most severe). The maximum total score is 63 (Beck et al., 1996). In screening patients' total scores for clinical purposes, the following guideline is suggested:

- 0-10: these ups and downs are considered normal
- 11-16: mild mood disturbance
- 17-20: borderline clinical depression
- 21-30: moderate depression
- 31-40: severe depression
- Over 40: extreme depression

Internal consistency Cronbach alpha coefficient for the BDI-II for a sample of 9 168 respondents conducted in 18 Arab countries is reported to be ranging between 0.82 and 0.93 for an outpatient population. The coefficients were consistently high, generally denoting good reliability (Alansari, 2006).

The researcher used the above five measuring instruments in Phase 1 to gather information about the experiences of the women. The researcher further explored the value of the data gained from the scales and the interviews to give an idea of the validity of the instruments to identify those feelings of the participants that the researcher was able to identify in the interviews. This was done to make decisions about the usefulness of the scales in the second phase of the research in order to evaluate the intervention.

Since this research deals with human beings as objects of enquiry, issues of ethical concern were at issue and will be explained.

4.3.4 Ethical Considerations

Permission in the form of a written letter from the Provincial Government of Mpumalanga (see Appendix G) and the University of Pretoria's Research and Ethics Committee was obtained to conduct the study (see Appendix H). Participation of the participants was voluntary. Informed consent was obtained from those participants who were willing to participate (see Appendix I). Records were stored in a locked filing cabinet in the researcher's office to ensure confidentiality in accordance with the law and in a manner that permits compliance with the requirements of the Ethics Code. The researcher took extreme care to avoid any harm to the participants. Traditionally, ethical concerns have revolved around the topics of informed consent (receiving consent by the participant after having carefully and truthfully informed her about the research), the right to privacy (protecting the identity of the participant), and protection from harm (physical harm, emotional or any other kind). Participants were made

comfortable by being reassured that their information would be private and handled confidentially, and that it would remain anonymous.

They were furthermore assured that they have the right to terminate their participation at any given time should they wish to do so (as indicated in the consent form). Taking into consideration the sensitivity of the topic, participants were given the freedom to express only that which they were comfortable with to express. Participants were provided with food and money for transport. Whenever there was a need for the participants to receive further psychotherapy, follow-up treatment was made available by the researcher (Fontana & Frey, 2000; Henning, Van Rensburg & Smit, 2004; Lavrakas, 1998; Neuman, 2000; Van Kammen & Stouthamer-Loeber, 1998). Since withholding treatment from participants would also be unethical, participants who required more help received treatment after completion of the study (Reichardt & Mark, 1998). The following section deals with the method that was utilised to analyse data.

4.3.5 Data Analysis

Data analysis is the process of bringing order, structure and meaning to the mass of collected data (De Vos, 2002a). In this study, the process of data analysis was exciting, as the researcher discovered themes and concepts embedded throughout the interviews. As the researcher continued with the data analysis, he wove these themes and concepts into a broader explanation of theoretical or practical import to guide his final report. Data analysis was the final stage of listening to hear the meaning of what was said (Antaki & Leudar, 1992; Fink, 1995; Jorgensen, 1989; King, Morris & Fitz-Gibbon, 1987; Miles & Huberman, 1994; Patton, 1997; Spradley, 1979; Strauss, 1987; West, 1990).

Data analysis began while the interviewing was still under way. After completing each interview, the researcher examined the data he had gathered, isolated the concepts and themes that described the world of the participant, and decided about areas to be examined in more detail. This preliminary analysis told the researcher how to redesign his questions to focus on central themes as he continued interviewing. After the interviews were completed, the researcher began a more detailed and fine-grained analysis of what the participant told him. In this formal analysis, the researcher discovered additional themes and concepts and was building toward an overall explanation.

The researcher made use of Rubin and Rubin's (1995) method to analyse and weave together the ideas, concepts and themes in the interviews. Rubin and Rubin's (1995) method of analysing data is based on grounded theory model, which attempts to build theory solely from the data at hand and in doing so emphasise theory building rather than theory testing. The core of the grounded theory approach is that theory emerges directly from the interview or observational data through a series of steps labelled analytical induction (Rubin

& Rubin, 2005). In Chapter 5, the researcher will describe how he coded the responses – that is, organising what the participants have told him – and how he interpreted the coded data so that the ideas would become clear to the readers. The researcher will also discuss how he combined ideas to interpret what he discovered in the light of other theories in the field (Rubin & Rubin, 1995).

Rubin and Rubin's (1995) method was used as follows in analysing the data:

- The researcher read and re-read the transcribed and translated interview data.
- While re-reading the interview data, the researcher assigned a numerical code to each meaningful topic.
- The researcher compiled a list of main themes from the previously coded data by grouping together topics and concepts describing related ideas and putting them into specific categories. The researcher assigned an alphabetical code to each category or theme (see Section 5.2).
- Data analysis ended when the researcher had found overall themes that enabled him to interpret the data in the context of other theories or existing literature. After the above steps had been completed, the results were discussed and presented (see Chapter 6).

Given his work experience with HIV-positive women, the researcher's colleague (a clinical psychologist for a period of seven years) also interpreted the data to enhance validity and comprehensiveness of the results.

The data gathered in the literature, the researcher's experience, the focus group discussions with colleagues and the case studies that were conducted, helped to identify significant misconceptions or irrational thought patterns of HIV-positive women, as well as ways to deal with these in a therapeutic context. From these data, a model of intervention was developed, as will be discussed below.

Phase 2: Implementation and Evaluation of an Intervention Model

The second phase focused on the implementation and evaluation of the therapeutic model that was used with ten HIV-positive women who served as the experimental group and ten women who constituted the control group. The details of Phase 2 will be discussed in detail below.

4.3.6 An Intervention Model

An overview is given of the intervention model implemented in therapy with HIV-positive women. An indication of the theoretical framework to deal with the women's experiences of being diagnosed with HIV (such as shock and disbelief; anger; powerlessness; self-blame and guilt; sadness; hurt and so on, as discussed in Section 2.4) will be discussed below. The intervention consisted of

eight sessions with each participant, dealing with the five commonly identified themes in Phase 1 of the study (see Section 5.2 for details). It must be noted that almost all of the techniques were used to address each theme. The procedure that was followed during the implementation phase will be explained in the section that follows.

Session 1: The researcher introduced himself to the participant in a one-to-one therapy situation. The nature of the research project was explained in order to obtain written consent for participation in the study. After the women had agreed to participate in the research, the interview started. The guideline questions for the interviews were used (see Appendix A). During this session, the researcher also gave out an information leaflet (see Appendix J) (before consenting) about the study, and administered five psychometric tests (see Appendices B-F) as a pre-test. Participants were informed that they would be seen for eight sessions of therapy at weekly intervals. Targets were set and altered at regular intervals.

To gain an understanding about their experience of HIV, the women were asked to draw a life map and to indicate where HIV/AIDS featured in their lives. During the therapeutic encounters, participants were encouraged to experiment with new behaviour, such as talking about HIV/AIDS, and to present to some degree both self-image and ideal self-image. They shared cognitively and emotionally their experiences of being diagnosed with HIV/AIDS and the stigma they encountered. Those experiences were interpreted and the role of HIV/AIDS in their lives was thus assessed. At the end of each session, homework assignments were given to the women depending on the data gathered during the session. For example, if the participant showed to be feeling suicidal, she was assigned the task to find a reason for living, which was meant to help her finding a purpose for living with the virus.

Session 2: The procedure that the researcher followed was that he followed up on the homework assigned to the participant during Session 1. During this second session, the researcher gathered information about the participant's feelings and dealt with one of the five commonly identified themes.

Other issues that were of concern to the participants were also dealt with in therapy. If the participant did not present with a specific theme, the following theme was addressed in this therapy session:

- Feelings of powerlessness, which may include loss of confidence and self-worth

The participants felt powerless about their HIV-positive diagnosis and saw themselves as worthless, which may have resulted in them losing confidence. In this instance, Socratic questioning and reality testing therapies were offered to the patient, and she was taught to question the evidence for the automatic thoughts. The researcher did that by asking, "what do you mean

when you say you are now worthless and have lost your confidence?” The irrational thoughts were questioned further by asking, “did you feel the same before you were diagnosed with HIV and how come you feel this way now?” The participants were further taught to look at the alternatives or options that were open to them, after which the therapist asked for alternative explanations or solutions and did that until as many as possible solutions were generated by the participants.

Once the participant can challenge thoughts that interfere with functioning (for example, an HIV-positive woman’s feelings of failure and worthlessness that can be addressed and modified by the therapist), she can consider the underlying assumptions that generate such thoughts, like blaming herself to an excessive degree (Beck & Weishaar, 1989). Homework was offered to the participants at the end of therapy sessions, for example, they were required to practise to think and talk positively about themselves.

Session 3: In this session, the homework that had been given to the participant was discussed. Other issues that were of pressing concern to the women were dealt with in therapy. Themes that were addressed in this session included the following:

- Feelings of guilt, which included past behaviour; anger that can be directed inwardly in the form of self-destructiveness or suicidal behaviour; regrets and negative self-evaluation.

An HIV-positive woman might have guilt feelings and also say “it is my fault that I contracted the disease”. In this instance, the role of the therapist was to help the participant to have alternative ways of appraising her situation by making her aware of the fact that any other person could suffer from HIV and that it was not her fault that she had contracted the virus. The therapist helped the participants to monitor their thoughts and beliefs. The participants were also helped to recognise maladaptive thought patterns such as over-generalisations and polarised thinking, and how to substitute these irrational thoughts with rational thought patterns. In this scenario, therapy aimed to change thought patterns, which in turn played a significant role in influencing behaviour and emotions. The women were taught to identify negative patterns in everyday contexts.

Each participant was offered homework assignments at the end of therapy to reflect on how her feelings of regret and guilt could possibly help to change her HIV-positive status.

Session 4: The homework that had been given to the participant was reflected upon, and the new issues arising in therapy were dealt with. Themes that were addressed in this session related to:

- Behavioural implications, such as self-pity; self-isolation; self-neglect; denial and suicide.

Due to the stigma related to HIV/AIDS, HIV-positive women might see themselves as being isolated by loved ones and thus neglect themselves. The researcher assisted the women by challenging their dysfunctional beliefs about their experience of internalised stigma and discrimination and promoted more realistic adaptive ways of thinking. If the participants presented with suicidal ideation, they were given a homework task to record and challenge their automatic thoughts to help them internalise the process of identifying and modifying negative automatic thoughts. Participants were assisted to change their suicidal behaviour by adopting a relatively positive belief. For example, if a woman said “I am a bad person, hence I deserve to die”, she was helped to refocus on another core belief. A new core belief she was taught to adopt would say, “I am a worthwhile person with positive and negative features”. Homework was given to the women at the end of therapy sessions as they were for example required to list good things about themselves and to frequently peruse the list, especially when they pitied themselves.

Session 5: During this session, the researcher first assessed the outcome of the homework assignment, as well as discussed any other problems that the participant presented with. The session was dedicated to exploring the following theme:

- The experience of the reaction of others

Participants who saw themselves as being discriminated against by others were empowered to deal with these issues as they were taught basic human rights issues such as anti-discriminatory laws. In instances where women were discriminated against, behavioural techniques such as assertiveness and social skills training were taught to empower them to effectively deal with internalised stigma and discrimination. This was done in situations where participants lacked assertiveness.

The participants were assigned homework tasks such as to practise assertiveness, and this was explored in the next session.

Session 6: In this session, the previously assigned task, as well as issues of concern to the participant was discussed. Session 6 aimed to address the following theme:

- Uncertainty about the future such as shock; fear of the unknown and confusion

Most women felt uncertain about their future following an HIV/AIDS diagnosis, and that led to anxiety. In such cases, they were offered stress management techniques in an attempt to assist them to cope. The use of a social support system that was taught as a coping strategy played a significant role in assisting them to cope. The decatastrophising technique was also utilised to help participants modify negative thinking. Participants were taught to question what would be the worst thing that would happen to them now that they were living with the virus. As a result, women learnt that their fears were irrational.

The women were tasked to plan their future for the next five to ten years.

In **Session 7**, the researcher allowed the participants the opportunity to report back on the Session 6's tasks. This session also addressed new issues that the participants presented with. The participants were offered a session on the coping strategies as well as problem-solving skills in order to assist them to cope with internalised stigma and discrimination. These strategies and skills included the following:

- Empowering women to help others by being involved in HIV/AIDS-related tasks such as teaching about the disease and by so doing they assisted themselves to cope.
- Encouraging the participants to form support groups with other HIV-positive women that could give them a sense of belonging. Making the participants aware that they were not alone, as others also lived with the virus and helping them to regard it as any other chronic disease (that is, seeing other HIV-positive people as models).
- Encouraging women to see HIV as a challenge and not as a punishment for bad behaviour (reframing). Reminding them that since they experienced stigma and discrimination directly, their perceptions of stigma were influenced by how they identified themselves (for example, as members of a stigmatised group) and how they perceived others (for example, as stigmatising) (Deacon et al., 2005).
- Encouraging participants to adapt their lifestyle by eating a balanced diet, adhering to treatment regimen and promoting the use of condoms (when engaging in sexual activity) as a means to combat the spread of HIV infection.
- Encouraging women to use their time effectively in order to accomplish their goals by setting goals for each day that could give women a purpose for living.
- Preparing the participants for the worst in dealing with internalised stigma and discrimination, in order to equip them for when they encounter stigma. For instance, asking women to imagine what will go through their minds when they are discriminated against and reminding them of the techniques they learnt during therapy, which assisted them

to cope. Helping participants uncover their dysfunctional and irrational thinking, reality-testing their thinking and behaviour, and building more adaptive and functional techniques for responding to internalised stigma and discrimination.

During the course of CBT, the participants experienced both success and setbacks. Such problems gave them the opportunity to practise new skills. As termination approached, the participants were reminded that setbacks were normal and had been handled before. The researcher asked each participant to describe how earlier specific problems had been handled during therapy. The researcher also used cognitive rehearsal by having participants imagine future difficulties and report how they would deal with them during therapy and in the next session. The final session consolidated gains and assisted the participant in employing new skills. It further reviewed the skills and techniques learned (Bea & Tesar, 2002; Beck & Weishaar, 1989).

Session 8: Therapy was terminated during this session as goals had been reached and the participant felt able to practise her new skills and perspectives (Bea & Tesar, 2002; Beck & Weishaar, 1989).

It must be pointed out that termination had been planned, even during the first session as the rationale for CBT was presented. Feedback from the participants aided the researcher in designing experiences to foster cognitive change and required that the participant assess personal therapeutic change (Beck & Weishaar, 1989).

Some participants had concerns about relapse or about functioning autonomously. Some of these concerns included cognitive distortions such as dichotomous thinking ("I am either sick or 100% cured") or negative prediction ("I will get depressed again and won't be able to help myself"). It was necessary in such instances to review the goal of therapy: to teach the participants ways to handle problems more effectively – not to produce a "cure" or restructure core personality. They were given training about psychological disorders such as the possibility of recurrent relapse, throughout CBT so that they would have a realistic perspective on their prognosis. In this session, coping strategies were reiterated to remind the participants about their perceptions. For example, if a woman felt she could not change her HIV status, she was reminded that there were things about her status she could change and others that she could not change.

This is a description of the therapeutic interventions that are possible to address the negative feelings and behaviour of women diagnosed with HIV. This intervention model was adapted according to the specific needs of each of the women when implemented in the therapy situation.

The five measuring instruments (Brief Cope Scale; Personal and Enacted Stigma Scale; Rosenberg Self-Esteem Scale; Beck Depression Inventory-II Scale) were used post-therapy in order to evaluate change that had taken place.

4.3.7 Evaluation of the Intervention Model

To evaluate the effectiveness of the intervention model, the following process was followed.

4.3.7.1 Participants

A sample of twenty black South African women living with HIV/AIDS, attending the clinic at the Witbank Hospital for treatment, and experiencing difficulties in dealing with stigma were approached to participate in the research. The criteria for the selection of these participants were exactly the same as in Phase 1. The women were informed about the nature and goals of the research and those who were willing to participate voluntarily were included in the evaluation process.

Systematic sampling was used to select the women, were the women assigned with number 1 comprised the experimental group and then the women assigned with number 2 comprised the control group. The ten women constituted the experimental group who would participate in the intervention (discussed in Section 4.3.6), while the other ten constituted the control group, who did not receive any intervention. The control group formed a waiting list group and received therapy once the first group had completed their intervention.

4.3.7.2 Design

A quasi-experimental design was used in the evaluation of the intervention. The term quasi means "having some, but not all of the features". This implies that the researcher is dealing with a design that resembles an experiment, but which is not exactly an experiment. A pre-test/post-test control group design was used in this study. This is a design in which at least two equivalent groups are given a pre-test, followed by a treatment and then a post-test measure. The advantage of this design is that it ensures that the participants are equivalent in terms of the dependent measure at the beginning of the study (Jackson, 2003). (See Section 5.3.1 for an illustration of the two groups and the interventions.)

One of the most basic ideas behind an experiment is that there should be at least two groups to compare. These two groups or conditions are typically referred to as the control group and the experimental group. The control group is the group of participants who are not exposed to any level of the independent variable and who serve as the baseline in a study. The experimental group is the group of participants who are exposed to some level of the independent variable (Jackson, 2003).

As stated above, a pre-test allows the researcher to assess whether the groups are equivalent in terms of the dependent measure before the treatment is given to the experimental group. After the treatment, change that occurred is assessed by comparing the pre-test measures for each group with their post-test measures. Thus, in this study the researcher did not only compare performance between the two groups on both pre-test and post-test measures, but also compared performance within each group from the pre-test to the post-test. The two groups were similar before therapy, according to both the parametric T-test and the non-parametric Mann-Whitney test. If the treatment indeed had some effect, there would be greater change from pre-test to post-test for the experimental group than for the control group (Jackson, 2003). The inclusion of the control group allows control for external events influencing the behaviour of the participants and thus enhances the validity of the intervention outcome.

4.3.7.3 Data-gathering instruments

Two ways of gathering data were used:

- Quantitative: Psychometric instruments – the five measuring instruments (Brief Cope Scale; Personal and Enacted Stigma Scale; Rosenberg Self-Esteem Scale; Beck Depression Inventory-II Scale) as discussed in Phase 1 were again used and they were administered to the participants pre-and-post therapy to assess changes that had taken place. The quantitative instruments were used to monitor those changes in experience and behaviour that were common to the participants.
- Qualitative: The therapist's participative observation of the progress in therapy. In order to account for specific experiences of participants, the researcher's process notes were used as qualitative data on the therapeutic process and the responses of the participants. The process notes were written according to these criteria:
 - 1 Context
 - Biographical data and place where the participant was seen
 - 2 Definition of the relationship
 - How did the participant present herself?
 - 3 Distance (Punctuating from the participant's point of view)
 - 3.1 Acceptance of reflections
 - How did the participant handle emphatic reflections of feelings?
 - What distance was maintained in a therapeutic relationship?
 - 3.2 How did the participant express herself?

- For example, did the participant blame others or did she take responsibility for her illness?

3.3 Manoeuvres and behavioural patterns

4 The participant's system

- Is her system supportive or does it reject and isolate her?

5 Hypothesis

- Her interactional style on the researcher and her primary family system and its effects

6 Symptoms

7 Goals of therapy

- Aiming to focus on the participant's inappropriate style (that is, dysfunctional beliefs about her experience of internalised stigma and discrimination)

8 Intervention used and the reaction of the participant to the intervention of the day

4.3.7.4 Data analysis

The results of the psychometric scales of the two groups of women in pre- and post-test were analysed quantitatively by using both the parametric T-test and the non-parametric Mann-Whitney test. The latter was probably more appropriate than the T-test, given the relatively small size of the sample. Although the results of the Mann-Whitney non-parametric test were used, it must be mentioned that the parametric T-test rendered the same results (Mendenhall, Beaver & Beaver, 2003).

The qualitative data of the therapy process notes were analysed by applying the method that was designed by Rubin and Rubin (1995) and that is specifically suitable for analysing case study data (see Section 4.3.5 (Phase 1); 5.3.2 (Phase 2)). A cognitive behaviour approach was also used for interpreting data (Beck & Weishaar, 1989). According to Rubin and Rubin (1995), a goal of data analysis is to find themes that both explain the study (research arena) and fit together in a way that it can promote an understanding. Sometimes the researcher can find an overall theme that ties the individual pieces together. In order to find an integrative theme, the researcher needs to step back and examine the smaller themes to see what, if anything, ties them together.

The researcher compared the initial session with other follow-up sessions to determine what had impeded a particular participant's progress in therapy in order to deal with that participant's difficulties. He then drew conclusions about

the intervention model – whether it was effective or not, in what regard it was successful, and for what aspects it was not successful (see Chapter 6).

4.3.7.5 Ethical considerations

A similar criterion as in Phase 1 was used and the ten control group participants eventually also received psychotherapy upon completion of the study.

4.4 ACCURACY AND RELIABILITY OF DATA

One way of determining the accuracy of data is to assess the reliability of the measure. Reliability refers to whether a measuring instrument is consistent or stable. In other words, instruments need to measure exactly the same way each time they are used. In addition to being reliable, measures must also be valid. Validity refers to whether a measure is truthful or genuine. In other words, a valid measure measures what it claims to measure (Delpont, 2002; Jackson, 2003). Data are useless if they are not accurate, valid and reliable (Bickman, Rog & Hedrick, 1998; Scott & Alwin, 1998). In this research, the reliability and validity of psychometric instruments were noted in other South African samples. The assumption was made that it would be reliable and valid in this study as well, because a similar group of people was used as participants in this study.

Quantitative and experimental researchers generally attempt to design, in advance, controls that will deal with both anticipated and unanticipated threats to validity. Qualitative researchers on the other hand, rarely have the benefit of formal comparisons, sampling strategies or statistical manipulations that “control for” the effect of particular variables. Qualitative researchers must try to rule out most validity threats after the research has begun, using evidence collected during the research itself to make these “alternative hypotheses” implausible. This approach requires the researcher to identify the specific threat in question and to develop ways to attempt to rule it out. It is clearly impossible to list here all, or even the most important, validity threats to the conclusions of a qualitative study. The two broad types of threats to validity that are often raised in relation to qualitative studies are researcher bias and the effect of the researcher on the setting or individual studied, generally known as reactivity (Maxwell, 1998).

Bias refers to ways in which data collection or analysis is distorted by the researcher's theory, values, or preconceptions. Because the values and expectations of researchers cannot be eliminated or “controlled” for, it is necessary to be aware of and understand how a particular researcher's values influence the conduct and conclusions of the study. Validity in qualitative research is stated to be the result not of indifference, but of integrity (Maxwell, 1998). In this study, the researcher's male colleague (who has been a clinical psychologist for a period of seven years) also interpreted the data to confirm or assure integrity and accurate interpretation.

Reactivity is a second concern that can influence the validity of qualitative data. In this research, the relationship of the researcher with the patient will have an important influence on the quality of the information the patient shares with the researcher as her therapist. However, eliminating the actual influence of the researcher is impossible. The goal in qualitative studies is not to eliminate this influence but to understand it and to use it productively (Maxwell, 1998).

It must also be noted that it is impossible to achieve direct equivalence of meaning in translation (Brennan & Levett in Paketh & De la Rey, 1997). While acknowledging this, the researcher strived to preserve the original meaning in the data by transcribing and translating with the assistance of two other people who are fluent in the participant's home language and English. As a result, the translation was not done in grammatically correct English, as some meanings would be lost if it were. The researcher and two other people kept the translation as close to how the participant spoke, so as to capture the meaning of the original.

The researcher's colleague also interpreted the data, in order to enhance the comprehensiveness and validity of the data interpretation. The quantitative instruments were used to monitor changes in experiences and behaviour that were common to the participants. The five psychological measuring instruments were used quantitatively, which allowed the researcher to assess whether the groups were equivalent in terms of the dependent measure before the treatment (individual CBT) was given to the experimental group. The researcher assessed any changes that may have occurred in each group after treatment by comparing the pre-test measures for each group with their post-test measures. These data were then compared with the qualitative data. It was important to use different data-gathering techniques to complement one another, as this also contributed to the validity of the results.

To account for specific experiences of participants, the researcher's process notes were used as qualitative data of the therapeutic process and the responses of the participants. The researcher also identified the point of change (given the intervention strategy used in the therapy process) and the reaction of the participant to the intervention of the day that contributed to the change that took place.

4.5 THE RESEARCHER'S ROLE

The 'researcher effect' is unavoidable in qualitative and quantitative research, since the participant is aware of being observed and the researcher is asking questions, recording answers and tape recording the interview (Huysamen, 1994; Judd, Smith & Kidder, 1991; Rubin & Rubin, 1995; True, 1989). In this study, the researcher was also aware of his role as a male researcher dealing with a gendered problem (that is, HIV-positive women). It was therefore important to try

to reduce researcher effect by making the participant as comfortable with the interview and the therapy process as possible.

As a general rule, Huysamen (1994) recommends that, where possible, the researcher should dress in more or less the same way as the participant. There may be resistance among residents of a squatter camp if a researcher arrives there being well dressed. Other factors over which the researcher has no control such as his/her gender, race, physical appearance and background, may have an effect on the responses provided by participants. Often there is the danger that the participant may view the researcher as an intruder. Especially in the South African context, HIV-positive women may view a professional male as an intruder who may not understand their experiences. These factors may cause participants to provide biased or even false information (Huysamen, 1994; Judd et al., 1991; True, 1989).

As a psychologist in a professional relationship with his clients, the researcher established a relationship of mutual trust with the participants and convinced them of the harmlessness of the study. Once allowed into the participant's confidence enough to ensure co-operation, the researcher had to put the participant at ease by making a pleasant comment or two that served to establish some point of commonality between them. A remark of admiration or familiarity with some object usually does quite well as long as the remark is not forced or false.

The researcher had to be careful not to say anything that could be regarded as evaluative, as participants had a tendency to regard the interview as a test and they had been conditioned to testing situations in school. This not only led them to think that the questions had "correct" answers (as mentioned previously), but also led them to remember being graded. Participants could furthermore attempt to discover whether they were giving the "right" answers (True, 1989). The researcher therefore had to reassure a respondent by saying, "it's your opinion we want. There isn't any right or wrong answer" (True 1989: 217-218).

Based on the information mentioned above, the researcher was aware of the researcher effect, both during therapy and the interpretation of the results. That is why he asked his male colleague to be involved in the interpretation of data, so as to obviate biasness. As a clinical psychologist, the researcher utilised his years of experience to enhance rapport, to understand what HIV-positive women were experiencing in order to assist them in dealing with internalised stigma and discrimination, and to recommend an appropriate intervention model.

Various aspects of quantitative and qualitative research design and methods that were used by the researcher to collect data have been discussed in this chapter. The results will be presented in Chapter 5, and discussed and integrated with existing literature in Chapter 6.

CHAPTER 5

RESULTS

5.1 INTRODUCTION

The current study constitutes a combination of both quantitative and qualitative research and its findings will be described in this chapter. Three colleagues who are clinical psychologists were used in Phase 1 (development of the model) as part of focus group discussions to determine themes to be addressed in therapy. The researcher's experience, available literature and five case studies of HIV-positive women were also used to gain an understanding of women's experiences of HIV and HIV-related stigma and to determine themes to be dealt with in therapy to help them in dealing with internalised stigma. In Phase 2 (implementation and evaluation of the model), ten HIV-positive women were seen in therapy to address issues of HIV-related stigma. They formed the experimental group and ten other women who did not receive therapy constituted a control group.

At the time of the interviews, both Phases 1 and 2 participants (clients) had been aware of their HIV status for a period of more than three months and were receiving antiretroviral treatment (ARVs) at Witbank Hospital. The women were in their early to middle adulthood, aged 22 to 40 years. All the interviews were tape recorded and the interview data was transcribed and translated by the researcher and two other people who are fluent in both English and the participant's language. Observations of non-verbal behaviour were included in the transcript (interview data is available on request). A qualitative analysis of the results was made both in Phases 1 and 2, using the method of Rubin and Rubin (1995). Quantitative data obtained in Phase 2 consisted of the five psychometric instruments used before and after therapy to monitor the changes in experiences and behaviour that were common to the women. This data was analysed using both parametric T-tests and non-parametric Mann-Whitney tests. To account for specific experiences of participants, process notes were used to record qualitative data regarding the therapeutic process and the responses of the participants. The results of these therapy sessions are presented below.

5.2 PHASE 1: PRESENTATION OF THE RESULTS

5.2.1 Qualitative Results

This section will focus on the presentation of the themes identified from a focus group discussion of psychologists as well as from the five case studies of HIV-infected women.

5.2.1.1 Focus group interview data

In this section, the researcher describes the results derived from the qualitative analysis of the focus group discussion with colleagues. The aim is to provide an in-depth understanding of HIV-positive women's misconceptions, the irrational beliefs that they experience on a day-to-day basis influencing their experience of HIV-related stigma and how the colleagues perceive the women's coping strategies. The researcher will further explain the cognitive behavioural therapy (CBT) strategies that colleagues suggested in assisting the women to cope with the experience of internalised stigma and discrimination. Rubin and Rubin's (1995) method was used to identify the main themes. Verbatim responses would be given to provide to the reader an understanding of what was meant by each theme. This is how the data was analysed (also refer to Section 4.3.5):

- The researcher read and re-read the transcribed and translated focus group interview data with the assistance of a male colleague who is a clinical psychologist.
- While re-reading the interview data, a numerical code was assigned to each meaningful topic.
- A list of all the meaningful topics was compiled as discussed below.
- The researcher compiled a list of main themes from the previously coded focus group data by grouping together topics and concepts describing related ideas and putting them into specific categories. Based on the experience of his colleagues, the researcher assigned an alphabetical code (A to E) to each category or theme that constituted one of the five commonly identified themes, as well as code F for coping strategies and problem-solving skills. The themes were thus clustered into meaningful categories (A to F) as is shown below:

A. Feelings of powerlessness (which may include loss of confidence and self-worth)

The HIV-positive women seen in therapy often experienced feelings of being stuck; powerless and trapped when they were told about their diagnosis. They experienced feelings of despair, hopelessness and helplessness, as many of them were breadwinners. The news about their HIV-positive status often caused them to feel disempowered. One colleague summarised the women's reactions as follows: "there are lots of feelings such as despair and helplessness about their diagnosis".

- B. Feelings of guilt (which include remorse about past behaviour; anger that can be directed inwardly in the form of self-destructiveness or suicidal behaviour; regrets; negative self-evaluation)

HIV-positive women often experienced anger directed towards the self, others or God. Their anger increased, especially in the case of married women who became regretful about having been faithful to their spouses, since their partners were not faithful to them. This realisation caused high levels of stress among women. They felt sad, hurt and betrayed by their partners when they received news about their diagnosis. Colleagues observed the women to be preoccupied with mixed feelings such as blaming themselves for contracting the virus and a lack of trust in men. This is often accompanied by the experience of guilt, and feeling overburdened and overwhelmed by feelings of remorse whenever they thought about their disease. To crown it all, some women's partners further traumatised them by blaming them for and accusing them of contracting the virus. For example, a colleague mentioned: "I had a case of a woman who had strong feelings of guilt ... she could not walk and talk, and could not do anything, which suggests that it was overwhelming for her".

- C. Behavioural implications (such as self-pity; self-isolation; self-neglect; denial; suicide)

The HIV-positive women often felt lonely and neglected, and they pitied themselves having received their diagnosis. One of the women is quoted to have said: "...that feeling of being alone comes up strongly. It is like I am all by myself; I have no other people to help me deal with this".

It was mentioned that HIV-positive women tended to isolate themselves and to deny having been diagnosed or living with the virus. They were often overwhelmed by feelings of having been abandoned by their loved ones, which often aggravated their self-isolation.

- D. Experience of the reaction of others

The psychologists reported that most of the women they see in therapy feared being rejected, stigmatised and discriminated against, especially when others knew about their status. They also experienced a fear of not being loved and many refused to disclose their status due to the expected reactions of others. For instance, a colleague remarked that: "people do not divulge to others because of fear of how people will react when they tell them".

- E. Uncertainty about the future (shock; fear of the unknown; confusion)

The women were seen to be shocked and confused upon being diagnosed with HIV. They feared the unknown and worried about their future, probably as a result of a lack of understanding and knowledge about their condition. They were fearful of what others would say when

they learnt about their status and were anxious about leaving their young ones behind. One of the researcher's colleagues made the following remark: "I come across patients who fear a lot. Fear of something in the future, like: 'If I happen to die, who is going to take care of my children and what is going to happen to them?'" The women were observed to be concerned about their loved ones and how they were going to survive if they were to die. They were obviously also chronically worried about dying soon, which aggravated their worries about leaving their children behind.

F. Coping strategies as well as problem-solving skills

The colleagues reported that the HIV-positive women they were seeing in therapy coped by re-labelling HIV/AIDS to be tuberculosis (TB). The women also considered their children as the reason why they should live, and hence they found a purpose in life.

Some of the women were coping by means of passive acceptance of their condition and were hopeful to be cured one day. They tended to rationalise, justify, deny and avoid dealing with their diagnosis. Whenever thoughts of death arose, they immediately distanced and distracted themselves from entertaining such thoughts. As colleagues in the focus group discussion pointed out, the avoidance of negative thoughts temporarily helped them to cope.

The colleagues found some of the effective CBT strategies to assist the women to be the correcting of cognitive errors or distortions about their disease through reality testing. Through this common method of cognitive restructuring, the women were taught to question the evidence for their automatic thoughts. The rules that guided their maladaptive behaviours were challenged, which helped the women to change the thoughts that underlie maladaptive behaviour. The women were taught to practise positive thinking about their HIV status. For example, a colleague admitted: "I usually say to the women that your status has given you time to plan your life and live every day like the last day of your life. I must admit that I always say I envy that. I am reframing ... I am showing them the bright side because they have been looking at the dark side. I also find that when I do that a lot, there is progress in terms of them coping".

Women were taught to identify and observe automatic negative thoughts that disturbed their thinking and to modify these negative thoughts. The colleagues further assisted the women to appraise their situation in a positive way, that is, they helped them to resume their roles as mothers, teachers, and neighbours and so on. Some hope was instilled in their situation and they were assisted to see other HIV-positive people as their role models.

Role modelling and assertiveness training was presented to women who experienced social problems related to stigma and discrimination. Their perceptions of stigma were influenced by how they identified themselves (for example, as members of a stigmatised group) and how they perceived others (for example, as stigmatising). The colleagues provided the women with a feeling of mastery over their feelings by asking them to engage in particular activities associated with a prescribed activity.

It must be noted that the researcher identified very similar themes in the focus group discussions with colleagues and in the case studies of HIV-positive women respectively. The themes identified in the women's behaviour will be discussed in the next section.

5.2.1.2 Case studies

Interviews were conducted with five HIV-positive women at Witbank Hospital to gain an understanding of their experiences of HIV-related stigma and discrimination in order to enable the researcher to develop an intervention model. Rubin and Rubin's (1995) method was also used to identify the main themes emerging from these case studies. As in the case of the focus group interviews, verbatim responses would be quoted to give an understanding of what is meant by each theme. The analysis of the data emerging from the case studies follows the same pattern as used for the focus group interviews and was conducted as follows:

- The researcher, assisted by a male colleague who is a clinical psychologist, read and re-read the transcribed and translated case studies interview data.
- While re-reading the interview data, a numerical code was assigned to each meaningful topic (interview data is available on request).
- A list of all the meaningful topics was compiled and will be discussed below.
- The researcher compiled a list of main themes from the previously coded focus group and case studies data by grouping together topics and concepts describing related ideas and putting them into specific categories. The researcher assigned an alphabetical code to each of the five commonly identified themes, as well as to the category of coping strategies and problem-solving skills. This categorisation was based on his experience, the available literature, the case studies and the focus group discussions with colleagues. The themes were clustered into meaningful categories (A to F), as is shown below:

- A. Feelings of powerlessness (including loss of confidence and self-worth)
Most women in the case studies felt powerless following their diagnosis and saw themselves as worthless. This resulted in them losing confidence and self-esteem. Two women lost partners upon disclosure of their status, which aggravated their feelings of hopelessness and helplessness. The

following is an example of a response by one of the participants: “my confidence has been lowered because I sometimes do not regard myself as a person”.

- B. Feelings of guilt (including remorse about past behaviour; anger that can be directed inwardly in the form of self-destructiveness or suicidal behaviour; regrets; negative self-evaluation)

Upon receiving an HIV-positive diagnosis, some women interviewed as part of the case studies felt guilty and blamed themselves for contracting the virus. Here follows an example of the response from a participant: “I have regrets about my life; I often say that had I known that I was going to contract the virus, I would not have had sex and would not have had a boyfriend”.

Women who participated in the case studies regarded themselves as different from others. They felt betrayed by their partners. They felt hurt and disappointed when they discovered their HIV status and perceived themselves as being punished by God. It was difficult for them to come to terms with their diagnosis and the fact that they had problems in coping with HIV/AIDS seemed to trouble them. They experienced thoughts of suicide, especially shortly after diagnosis, were depressed and mainly feared dying of AIDS. Some women generalised all negative feelings to be related to HIV and they tended to blame themselves or others for contracting the virus, instead of taking responsibility for the disease.

- C. Behavioural implications (including self-pity; self-isolation; self-neglect; denial; suicide)

Given the nature of the stigma related to HIV/AIDS, women who participated in the case studies tended to perceive themselves as being different and not loved by others. They displayed a tendency to isolate and neglect themselves since they were living with the disease. One woman said: “I regard myself as different from other people and I am not coping well with that. I thought of committing suicide as a way out of this situation”. Another woman said: “my mood is low. I distance and isolate myself from others. I think that people are happy while I am sick and still they would continue to ask me how I feel”.

- D. Experience of the reaction of others

Some women who participated in the case studies felt uncomfortable and scared when they were among others, because of the stigma and discrimination related to HIV/AIDS with which they were faced. They were also afraid of losing partners when the truth about their status became known. People’s negative comments about HIV/AIDS further caused them not to cope well. For example: “my life has changed a lot as I used to be free but now I am not. For example when I sit with other people watching TV and HIV is the subject; I suddenly change as if I am not the same

person. There is a thing that tells me that people know about my status. I feel as if I am transparent and that they know about me (*referring to her HIV status*). Even if I am sitting with people who are just talking about this disease, I usually tell myself that they know about my status and they are passing remarks to make me feel bad”.

Most of the case study women’s experiences were observed to be due to internalised stigma – that is, fear of being stigmatised and some women who disclosed their status, experienced people to be really discriminatory. Two of the women indicated that they lost their partners when they found out about their status.

- E. Uncertainty about the future (shock; fear of the unknown; confusion)
Most case study participants had a preconceived idea that an HIV diagnosis meant death and that they were going to die in the near future. This obviously made them to feel uncertain about the future. They were scared and surprised to discover that they were living with the virus and feared leaving their children behind. For instance: “I become so scared that I have to start to drink medication and that it is indeed true that I am going to die. That scares me”. In addition, some of the women were in denial of experiences related to their condition and denied reality by not thinking about the future. The women were stressed about not getting well and about dying, and they had no respect for themselves. They were chronically worried about losing their partners when they found out about their HIV status.

Themes that were mentioned by the women but not by the colleagues were generalising all negative feelings that they experienced to be related to HIV. They stated that they were stressed about death and not getting well. The women in the case studies indicated that they thought people suspected that they were living with HIV/AIDS, even if they did not disclose their status to them, and they tended to lack respect for themselves.

- F. Coping strategies as well as problem-solving skills
The women interviewed by the researcher tended to cope by using social support they received from others and by changing their lifestyle (eating a balanced diet, using a condom and adhering to treatment regimen). Their children gave them a reason to live whenever they thought of suicide and being faithful to their partners was also important. They kept themselves busy by keeping company with others and one woman helped herself to cope by telling people about the disease. Preparing themselves for the worst (decatastrophising) in terms of dealing with stigma and discrimination prevented them from being disappointed whenever they encountered difficulties. They reframed their negative situation by thinking positively about their disease, for example, they regarded themselves as

not the only ones living with the disease. They also kept on doing the things they wanted to do and tried not to regret living with the disease.

The women further coped well by regarding themselves to be similar to others and disregarded stigma and discrimination by disqualifying those who discriminated against them because they do not know about their status. This implies that they think that others, who discriminate against them do not know their own status, therefore cannot be taken seriously. They showed to be future orientated, and used the time they were left with effectively by not indulging in substance abuse such as smoking and drinking alcohol. They accepted HIV like any other chronic disease, which enabled them to cope. Religion was also used as a way of coping, and it assisted the women to gain strength and courage to deal with their disease. Seeing other HIV-positive people as their role models and accepting that many other people were also living with the virus further boosted their coping efforts. This implied that they were not the only ones suffering from this disease and as such they were not alone. The HIV-positive people they looked up to and used as role models were the people that openly disclosed their status on national television and others who lived with them in the community.

The ineffective coping strategies identified among the women involved minimising the seriousness of their diagnosis by regarding HIV to be similar to TB. This implied that they would probably not adhere to the treatment as strictly as was necessary, which could well result in re-infection and them spreading the disease. Some of the women did not disclose their status to others and avoided having partners, so as not to have to disclose. These coping strategies were possibly adopted to avoid being subjected to the stigmatising connotations related to HIV/AIDS. The women also showed passive acceptance of their disease and denied reality by not thinking about the future. Thus they became isolated and did not get the necessary support.

When diagnosed as HIV positive, the participants were shocked to a point where it was difficult for them to accept or come to terms with their diagnosis. They consequently resorted to defence and coping mechanisms of denial. For example, "I do not regard myself as a person living with this disease; I do not think about it and I think that I still have a lot of time to live".

5.2.1.3 Quantitative results

The five psychometric instruments planned for monitoring change in experiences and behaviour in Phase 2 was used with women as part of the case studies, to quantify women's experiences and to explore the validity of the instruments for this group of women. The psychometric instruments were used to assess

women’s coping styles, experience of stigma, self-esteem and depression. The psychometric scores of women that were part of the case study are given in table 5.1 and discussed thereafter (see Appendix K for the summary of all the raw scores of women involved in the case study interviews).

Table 5.1 Scores of women involved in the case study interviews

	N	Range	Mean	SD	Min	Max
Depression (BDI-II)	5	0-63	12.0	7.71	5	25
Self-esteem (RSES)	5	0-30	4.2	5.76	0	14
Enacted stigma	5	0-22	3.4	3.85	0	10
Internalised stigma	5	1-64	30.8	7.09	22	41
Coping positive (Brief Cope)	5	0-48	37.8	6.10	28	43
Coping negative (Brief Cope)	5	0-36	23.6	5.55	15	28

There were five HIV-positive women who formed part of the case study interviews (N=5). The mean score for the Beck Depression Inventory-II (BDI-II), which is used to assess depression, was 12.0 and scores ranged from 5 (normal ups and downs) to 25 (moderate depression) for these group of clients. This suggests that women involved in the case study interviews on average experienced mild mood disturbances. This corresponds with what women said during interviews, as one woman remarked: “...I thought of committing suicide as it is hard for me to live with this disease”. When one looks at the detail of item 9 (I would like to kill myself) of BDI-II, a similar pattern of suicidal thoughts or wishes is noted. Items 2 (pessimism) and 18 (changes in appetite) were often endorsed by women and they were most identified as feeling depressed with these two items (2 and 18).

The mean score for the Rosenberg Self-Esteem scale (RSES) that is used to measure self-esteem was 4.2 and it ranged from 0 (greater self-confidence) to 14 (lower self-confidence). This implies that women involved in the pilot study were on average experiencing more positive self-esteem. This corroborates with what most women said during interviews, as one woman indicated: “I still regard myself to be similar to others”. A similar pattern was noted on the RSES scale when one looks at item 6 (I am as good as other people).

Enacted stigma assesses the real experience of discrimination. It assesses 11 types of behaviour that could be discriminative in interpersonal relationships like avoiding interaction, ending a relationship, forms of verbal and physical abuse. The mean score for this scale was 3.4 and scores ranged from 0 (no experience of community stigma) to 10 (high experience of community stigma) for this group of women. It indicates that the women were not experiencing high levels of discrimination in their interaction with other people in their community. The reason for this is that only two of them had disclosed their status to others. The two women who disclosed experienced negative consequences, like one woman

said: “my partner left me when he discovered about my HIV status”. The women’s experiences were accurately captured in the enacted stigma scale. Some women stated that people from the community act as if it is their fault that they contracted the virus and as such they have been called bad names.

Internalised stigma focuses on the person's own experience of stigma such as “I feel ashamed that I have HIV” and expected discriminatory behaviours of others. The mean score for this scale was 30.8 and scores ranged from 22 (moderate stigma) to 41 (high stigma). This suggests that women involved in the case study interviews on average experienced high levels of internalised stigma due to HIV/AIDS. This was further confirmed by their responses, as one client pointed out: “I feel like I am being punished ...” Items 3, 4, 5, 7 and 9 were the highest frequency indicating some women’s stigmatising experience.

The Brief Coping scale is used to determine the coping responses of participants both positively and negatively. Positive coping assesses types of behaviour such as, positive reframing, religion and acceptance. The mean score for positive coping was 37.8 and scores ranged from 28 (poor coping) to 43 (good coping). It means that the women had moderate positive coping skills. The positive coping styles used mostly by women were active coping, positive reframing, acceptance, religion and utilising emotional support. For instance, a woman mentioned: “I am trying to live and to accept my diagnosis” – this is a confirmation of the quantitative finding. The negative coping scale assesses types of behaviour like denial, substance abuse, self-blame as negative ways to cope. The mean score for negative coping was 23.6 and scores for this group of clients ranged from 15 (average coping) to 28 (poor coping), which implies that, additional to positive coping strategies, women also used various negative ways of coping. The women were using alcohol to make themselves feel better and criticising themselves too. This corresponds with the information the women gave in the interviews. For example, a client said: “I have been blaming myself for contracting this virus”. In this instance, it could be noted that the qualitative interviews were corresponding with the scores of women on the negative coping scale.

In conclusion, the findings indicate that the same patterns of experiences and behaviour were found in the results of the psychometric instruments and in the interviews with HIV-positive women. This lends some support for the validity of the instruments and enabled the researcher to use these instruments in the evaluation of the intervention in Phase 2.

5.2.1.4 Summary

The goal of Phase 1 was to gain in depth understanding of women’s experiences of HIV and internalised stigma related to HIV and to develop an intervention model. The following methods were used to gain understanding: a focus group

discussion, the researcher's experience, available literature and five case studies of HIV-positive women. From the data obtained themes were identified to be dealt with in therapy. Five psychometric instruments were also used in the case studies to determine the level of experienced depression, self-esteem, internalised and enacted stigma, and types of coping strategies used. This was also done to determine the appropriateness of using these scales in this population. The themes identified in Phase 1 of the research were used to develop an intervention for women (described in Section 4.3.6).

The themes were the following: 1) Feelings of powerlessness (including loss of confidence and self-worth); 2) guilt feelings (including remorse about past behaviour; anger that can be directed inwardly in the form of self-destructiveness or suicidal behaviour; regrets; negative self-evaluation); 3) behavioural implications (including self-pity; self-isolation; self-neglect; denial; suicide); 4) the experience of the reaction of others, 5) uncertainty about the future (shock; fear of the unknown; confusion).

This intervention developed in Phase 1 was implemented over an eight-week period to evaluate the effectiveness of the intervention in changing women's experiences of internalised stigma. In the next section, a presentation of the implementation and the evaluation of the model (Phase 2) will be discussed.

5.3 PHASE 2: PRESENTATION OF THE RESULTS

In Phase 2, the researcher implemented and evaluated the model. The quantitative results (outcome evaluation) will be presented first and thereafter the process evaluation done in a qualitative way.

5.3.1 Quantitative Results

The focus of this section is on the presentation of the results of the pre- and post-evaluation using five psychometric instruments. These instruments were administered pre-and post-therapy to the ten female clients in the experimental group and ten women in the control group who did not receive therapy. This was done in order to monitor changes in experiences and behaviour that took place as a result of therapy. The comparison of the results is discussed below.

The pre- and post-scores were analysed using both parametric T-tests and non-parametric Mann-Whitney tests. The result of the Mann-Whitney non-parametric test was used because of the small sample size involved. Thus it is probably more appropriate than the T-test, given the relatively small size of the sample. However, it must be mentioned that parametric T-test gave same results. The raw scores of the clients in the experimental and control groups on the five psychometric scales are presented in Appendix L.



Firstly, the experimental and control group's scores obtained before the intervention were compared to make sure that the two groups were similar to start with. The researcher had to verify that the two groups were comparable prior to the intervention so that any differences after the intervention could be ascribed to the intervention and not to inherent differences between the two groups. Secondly, a comparison of the changes between the before and after scores (score obtained before intervention subtracted from score obtained after intervention) for the experimental and control group was done to determine whether the experimental group's scores changed significantly more than those of the control group. In other words, the five psychometric tests measured whether the intervention model made a difference to the experimental group that was different from the results in the control group (see Table 5.2).



Table 5.2 Comparison of experimental and control group scores

	N	Experimental group X(SD)	Control group X (SD)	Mann Whitney	P-value	Exp min	Exp max	Contr min	Contr max
Comparison of pre-test scores									
Coping negative score before (Brief Cope)	10	20.3 (7.4)	22.5 (4.3)	44.5	0.6761	12	30	13	27
Coping positive score before (Brief Cope)	10	37.0 (6.7)	33.2 (9.6)	61.0	0.4039	26	45	21	46
Internalised (Personalised) stigma score before	10	37.7 (6.8)	42.4 (6.8)	33.0	0.1979	27	46	30	51
Enacted stigma score before	10	5.9 (3.9)	6.1 (4.0)	48.5	0.9088	0	14	0	12
Self-esteem (RSES) score before	10	8.5 (4.3)	9.6 (7.1)	49.0	0.9396	2	14	0	20
Depression (BDI-II) score before	10	28.1 (12.7)	24.3 (6.2)	54.5	0.7335	13	48	16	34
Comparison of change scores									
Coping negative change (Brief Cope)	10	7.8 (6.9)	0.1 (3.4)	80.5	0.0208	-4	15	-5	5
Coping positive change (Brief Cope)	10	6.4 (4.8)	0.7 (5.3)	76.5	0.0438	0	15	-12	5
Internalised (Personalised) stigma change	10	-15.1 (7.7)	-6.1 (7.1)	19.5	0.0207	-25	-5	-21	2
Enacted stigma change	10	-2.1 (3.9)	-1.0 (3.5)	41.0	0.4930	-10	3	-8	4
Self-esteem (RSES)change	10	-7.8 (4.3)	-2.2 (2.7)	14.0	0.0061	-13	0	-8	1
Depression (BDI-II)change	10	-19.2 (9.8)	-0.6 (5.9)	3.0	0.0004	-32	-9	-12	8

Before the intervention no statistically significant differences were found on the five scale scores between the experimental and control group (Table 5.2). Both the parametric t-test and the non-parametric Mann-Whitney have p-values greater than 0.05 for all the scales. There was therefore no statistical evidence of a significant difference, before the intervention, between the coping styles, internalised stigma, enacted stigma, self-esteem and depression scores for the experimental and control groups. These two groups are therefore comparable.

After the intervention, statistically significant differences were found in the changes to the scores of the experimental and control groups for four of the five scales. The enacted stigma changes were not significantly different between the experimental and control groups. This suggests that the intervention had a statistically significant different effect on the scale scores of the experimental group with regard to the four scales, in contrast with the control group. Both the parametric t-test and the non-parametric Mann-Whitney test indicated a statistically significant difference between the experimental and control group with p-values less than 0.05 for these four scales. This means that the experimental group had less negative ways of coping and more positive ways of coping after the intervention ($p < 0.05$). The level of the women's depression ($p < 0.001$), as well as of internalised stigma ($p < 0.05$) was statistically significantly lower following therapy. Women in the experimental group showed significantly higher self-esteem after the intervention ($p < 0.01$), which suggests better ways of dealing with stigma. It could therefore be noted that therapy had a positive impact on the women in the experimental group.

The positive impact of CBT can be noticed in the experimental group's less negative ways of coping as observed by the researcher on the Brief Cope subscales such as items 10 (denial) and 14 (self-blame) where the experimental women scored higher (3) before therapy to less (0) after therapy. The experimental group showed more positive ways of coping following therapy as seen on some subscales such as items 1 (active coping), 2 (planning), 3 (positive reframing), 4 (acceptance) and 7 (using emotional support) – where they scored higher (3) after therapy as compared to 0 before therapy, which is lower – suggesting that women were accepting to be living with their disease. The women's depression level was lower post-therapy as observed during the therapy sessions that they realised that they still had reasons for living – that is why they scored higher (3) on some items of the BDI-II subscales such as 1 (sadness), 4 (loss of pleasure) and 9 (suicidal wishes) pre-therapy compared to a lower score of 0 post-therapy. The experimental group women showed higher self-esteem after the intervention as noticed on the RSES subscales such as items 8 (I think I am a failure) and 5 (I feel useless at times) where they scored higher (3) before therapy to less (0) after therapy. This may be because therapy assisted them to regard themselves to be similar to others. A change was also noted on the experimental group women that indicated better ways of dealing with stigma on the internalised stigma subscales such as items 1, 3, 5, 7, 15 and 16 (see Appendix C for details) where women scored higher (4) before participating in therapy sessions to less (1) after the intervention. In this instance, therapy may have been effective in enabling women to think that getting HIV is not a punishment of bad behaviour. This corresponds with the information the women gave in the interviews. For example, client 4 said: "I have not done anything wrong for contracting this virus ...". In this instance, it could be noted that the qualitative interviews were corresponding with the scores of women on the internalised stigma scale.

With regard to enacted stigma, no significant change was found in the experimental group compared to the control group. This is understandable, given the nature of some of the options on this scale, such as: “my partner left me because I am HIV+”. The responses of the women could indicate experiences that had happened before the intervention took place, since the questions in the post-test did not specify experiences since the therapy started. The intervention model would also not have made a difference in other people’s reaction towards the client. Though, if people feel different about themselves they will be able to handle the reaction of others differently. Additionally, others may also act differently towards someone who is confident than towards someone who is not.

In conclusion, the findings indicate that the experimental group experienced less depression, internalised stigma and negative coping, as well as higher levels of self-esteem and positive coping after having participated in eight therapy sessions, compared to the control group.

The qualitative evaluation of the intervention will focus on the reactions of women in therapy and will enhance understanding of the quantitative results. The qualitative description of responses and experiences will be presented in the following section.

5.3.2 Qualitative Results

In this section, the researcher will present an overview of the therapeutic process and outcomes after the therapeutic process for the ten female clients who constituted the experimental group. Eight sessions were held with each of the women at weekly intervals. Verbatim examples will be provided to give an insight into the use of the CBT techniques and the participants’ reaction to the techniques. Results will be presented using Rubin and Rubin’s (1995) method of identifying main themes, as described in the previous sections. The researcher compiled a list of main themes from the previously coded data by grouping together topics and concepts describing related ideas and putting them into specific categories. The researcher assigned an alphabetical code to each of the five commonly identified categories or themes, as discussed in Section 5.2.1.2. The ten clients who participated in the case study will be discussed below. The results of each participant are dealt with separately. Careful consideration was given to the amount of background information to be provided due to the sensitive nature of the study.

Participant 1

Session 1

Based on the process notes, the following remarks can be made about this client.

1. Context

She was a 40-year old woman who was seen at the Wellness Clinic at Witbank Hospital. She was referred by the nurses for the purpose of this research to be assisted in dealing with the HIV-related stigma and discrimination that she was experiencing. The client reported that she was not married and had three sons, aged 23, 17 and 8 respectively, and a daughter of 15 years old. The daughter was troubling her because she refused to follow her instructions. This relationship seemed to be a major cause of stress in her life at the time of therapy and she reported to have lost weight as a result of her daughter's inappropriate behaviour. She indicated that she dealt with her frustrations by beating and shouting at her children. For example: "I was even beating them this morning before I came to see you". Her two younger boys and daughter were living with her, while the eldest son was studying at university. Her children knew about her HIV status, but not other family members and relatives, because she feared that they might discriminate against her. She was concerned about who would take care of her children after her death, especially of the youngest son. She had no proper support system after the death of their grandparents. Her main worry was that her children would grow up without parents. She was not married to the fathers of her children, and they were also not involved in her or their children's lives because they had already died. The only exception was the daughter's father who frequently saw her during school holidays. The woman pointed out that she herself had had a traumatic upbringing because she did not know her father and her mother suffered from chronic mental illness from the participant's early childhood. As such, she indicated that she was just brought up "by the grace of God" because she did not receive proper parental guidance.

She felt that God had not protected her from contracting the virus, despite knowing how she grew up. She was blaming God for that. She did not currently date any person and lacked trust in males. For example: "I do not want to hurt myself any longer even if I feel lonely at times. I think I have decided that I do not want men in my life". At the time of the first session she was unemployed, which added to her being stressed. She had earlier worked as a bus driver until she became sick. After being diagnosed with HIV she withdrew and isolated herself from others by not getting out of the house. She kept herself busy by watching television at home instead of thinking about her diagnosis. She presented with sadness, regrets and a low self-esteem.

2. Definition of the relationship with the researcher

The client entered the relationship in a "one down" (inferior) position and she maintained that throughout all the sessions. Her tone of voice was high and she maintained eye contact most of the time.

3. Distance (Punctuating from the client's point of view)

3.1 Acceptance of reflections

The client maintained an appropriate distance by being involved during therapy and accepted empathic reflections of feelings.

3.2 How did she express herself?

The client was congruent when she spoke about her situation and lots of emotion was expressed because she cried a lot. She presented herself as helpless and depressed, appearing to be out of control of her current situation. This could be interpreted as learned helplessness. She was not taking responsibility for her disease and kept on blaming it on God and her past traumatic upbringing as she indicated to have grown up without a father. By blaming God and her upbringing, she seemed to have an external locus of control.

3.3 Manoeuvres and behavioural patterns

A pattern of closeness was maintained throughout the therapy process. Manoeuvres for closeness were observed when the therapist reflected feelings and the client accepted them. She was also manoeuvring for sympathy and understanding when she expressed her feelings by crying a lot.

4. The client's support system

The respondent's parents were both deceased, and she had no support from family members and relatives. She was also scared to disclose her status to them because she feared being discriminated against. Her support system comprised of her three sons and daughter. There was a symmetrical relationship between her and the daughter, which was characterised by ongoing conflicts. She furthermore distanced herself from her own relatives by not sharing with them her intimate fears about living with HIV. Thus she was possibly depriving herself of the support she could hypothetically have received from relatives. What she was modelling to her daughter was that one should not get too close to the loved ones, because they might respond by rejecting you.

5. Hypothesis

The respondent had clearly assumed that her relatives would reject her, meaning that she had cognitive distortions of mind reading. She thus felt rejected by her potential support system (relatives). Her interactional style had a distancing effect and isolated her from any support. Her daughter's style matched her own, because the more the daughter tried to get closer to her, the more the participant employed conflict to distance and isolate herself from her daughter. HIV/AIDS is referred to in religious terms as a punishment from God as was the case in

previous research (Aggleton & Chase, 2001). Given such stigmatising connotations attached to the disease, the participant understandably feared disclosing her status to relatives and others in the community.

6. Symptoms

The woman preferred to isolate herself and thus avoided social interaction with others. She also modelled this attitude to her daughter, with the resultant conflict in the mother-daughter relationship. The other symptoms she was experiencing were self-isolation, feelings of helplessness, regrets and depression.

7. Goals of therapy

The aim of therapy was to assist the participant to deal with her inappropriate style (that is, feeling depressed, regretful and helpless, and isolating herself from others) and to empower her to deal with internalised stigma and discrimination so as to have healthy interpersonal relationships.

8. Type(s) of intervention used and the reaction of the client

The woman thought that God had not protected her from contracting the HI virus. She was worried about dying and leaving her children behind. A positive cognitive reframing technique was consequently taught, which seemed to be an unfamiliar concept to assimilate in her life. The researcher reframed her diagnosis by stating: “the disease you are suffering from offers you a chance to think about what to do with your children before you die as you are on treatment that will prolong your life”. She was encouraged to plan with her eldest son about what to do with his siblings if she dies, because she said that he is a responsible person. She responded negatively by saying: “even the same child that one trusts so much – one may never know what is happening with him as he might also contract the virus”.

She blamed God for her sickness and remarked: “I also think that God has abandoned me because He knows my life and did not show mercy towards me. He knows how hard it was for me to grow up without parents”. The researcher stated: “it does not necessarily mean that you are being forsaken. So you do not have to regard yourself as a rejected person”. (Identifying, challenging and changing negative automatic thoughts and assumptions.) He further challenged the woman’s thoughts by saying: “did you regard yourself to be rejected before you were diagnosed?” Her response was: “no”.

A homework assignment was given to her, namely to think of a thorough plan about what to do with her children if she dies. She was tasked to identify a responsible person or relative who could take care of the children. The purpose of the assignment was to assist her to have a tentative or workable goal, instead of ruminating on negative thoughts. If she identified someone, she would have to

disclose her status to that person so that he/she would have a thorough understanding of her arrangements for her children.

Comments: She found the assigned practical task to be easier than the call to change her thoughts, as the former could fit more easily into her perceptions. She showed slight improvement, which was evident from her remark: “I tell myself that I am going to be all right”. It seems that the concrete assignment to identify someone to look after her children worked fairly well. However, positive cognitive reframing, identifying, challenging and changing negative automatic thoughts and assumptions could not really be grasped, possibly because she was not familiar with these techniques. Perhaps the other reason for her failing to change her thinking at this stage is that several strategies were presented at once.

Session 2

Her uncertainty about the future, as well as the assigned task was explored in this session. She said the following about her previously assigned task: “I thought of it, as I have four children; one being a girl whose father is married to someone else. My girl loves her father a lot and can stay with him if I die. The other two children can stay with my eldest son as we agreed. I feel better since I have this plan in place”. It must be noted that she did not disclose her status to the father of her daughter to agree that he takes care of her as per agreement of the assigned task. However, the daughter’s father showed to be willing to take care of her.

Some coping strategies were taught by the researcher in order to help the client become aware that she could use the social support of others such as her son and the daughter’s father to cope and to be less worried about other issues. The woman agreed by nodding her head. Positive cognitive reframing of her situation was taught to assist her in thinking of her diagnosis in a positive way: “you must be grateful, as you seem to have a responsible son who possibly understands your current situation and has agreed to take care of the others when you are dead. So have a positive way of looking at it”. She reacted: “I do understand you”.

When asked if there was anything else that she wanted to raise for therapy, she said: “I have a problem of work and I am sometimes requested to come and work, as I am a driver. My worry is whether I will be able to work even if I have this disease?” The researcher confronted her negative self-perceptions about the disease: “do you perhaps know why you cannot work? It is because you are convincing yourself that you cannot work any longer since you live with the disease. What prevents you from doing the work now as you used to do it before you were diagnosed? You are given a chance to work and you seem not to see it. How many people who have this disease are still working?” (Identifying,

challenging and changing negative automatic thoughts and assumptions.) She answered: “many of them”.

Alternative ways of thinking were suggested: “such people work as long as they can and are able to take proper care of their health. You can still work, so you need to have a better way of looking at your situation. Pay careful and thorough thought to this matter, since it may give you a better perspective of yourself”. She responded: “thank you so much and I want to ask you something (*whilst laughing*), but it is difficult to ask it (*continued laughing*). Is it possible to date someone if you have this disease?” The researcher taught her coping strategies by explaining that she can date if she takes proper preventative measures when it comes to engaging in sexual activity. She seems to limit herself, as if her life was over. She was pleased to hear this. Her homework assignment was to think of a future plan for the next five to ten years.

Comments: She seemed to be progressing well as a result of the previously assigned task. It proved to be effective in alleviating her worries about who would take care of her children if she were to die, as she mentioned above. It could be noticed in this session that the assigned task made a difference in her life. Identifying, challenging and changing negative automatic thoughts and assumptions proved to be effective in making her aware that she could still be involved in other activities, such as dating someone and the changing of misconceptions of HIV made the difference as it started the change process. The researcher felt that thinking differently about HIV could have also started the process of change. Positive cognitive reframing and coping strategies however proved not to be that effective at this stage of the therapy.

Session 3

In this session we explored the client’s homework assignment about her future plans and she stated: “I am prepared to work for the Lord these last days of my life. I even wish I can go to a Bible college to teach a lot about this disease in churches. Furthermore, I wish to see all my children finish school and having their own families, especially my first-born child. I also want to drive a nice car (*tone of voice elevating as she was emphasising that*) and stay healthy. I have started talking to others about this disease since I saw you”. When asked about how people were reacting now that she was disclosing her status, she said: “some people become blessed and others want to know about their status and they go to test. Many people come to see me for help and they now love me and I become embarrassed as I did not want my neighbours to know that I have this disease. “

The woman blamed herself for her disease, felt guilty and did not want neighbours to know about her HIV status. Her anxiety about disclosing her status to neighbours was confronted: “how come that you are saying that you did not want neighbours to know about your status when you have started speaking

publicly about the disease?” (Identifying, challenging and changing negative automatic thoughts and assumptions.) She responded that she previously disclosed to someone who betrayed her trust. She was very angry about that. She mentioned that she was also worried about her children thinking that others would tease them about her HIV status. That is why she was feeling guilty about it.

A positive cognitive reframing of her negative thoughts and feelings of guilt was once again taught: “you do not have to feel bad about what previously happened to you ... it is no use feeling guilty and ashamed as you are already living with this disease. You rather focus on the future instead of feeling guilty and blaming yourself for having the disease”. She responded: “yes”. Coping strategies were educated to enable her to deal with her guilt feelings: “your plan is to address people to inform them that they can avoid contracting the virus and talking about this disease to others might help you to cope and deal with it, while at the same time you will be helping others as well. Your neighbours and others will ultimately know”. She seemed to be agreeing with these suggestions.

Her feelings of guilt were further challenged: “how would guilt feelings help you cope?” She responded: “it will not”. He further said: “it is of course not going to help you, as you will not achieve anything at all because of it”. To which she replied: “I understand”. She was paradoxically assigned a homework task to reflect on how feelings of guilt would help her to cope. The rationale behind this assignment was to try to empower her to recognise that her guilt feelings would not assist in dealing with stigma.

Comments: The client seemed to be responding well to the idea of identifying, challenging and changing negative automatic thoughts and assumptions because she could now face people and talk about the disease. The homework assignment she was given facilitated her progress in therapy because it proved to make a difference in her life as there was a drastic change – because she was looking forward with excitement. She was starting to look at alternative ways of coping and dealing with stigma as it was seen that she was talking to others about her disease. What went through the researcher’s mind was that she was really reacting unbelievably well. I think what made the change was that she was now seeing herself as “normal” and able to do “normal” things such as working, dating and talking to people.

Session 4

The woman’s feelings of powerlessness as well as her assigned task were explored. She said that she has started talking also with neighbours, especially because therapy has empowered her. She used to quarrel with neighbours if they dared to ask her about it. She was even free towards the people who do home visits because she was no longer locking herself in the house. She remarked: “earlier I did not even want them to come to my house since

neighbours would know that those people who do home visits are doing that for people who have this disease”. She further reported that they were there the previous day since she did not lock them out and they had a long conversation. She mentioned that she was thinking of starting a care group in her neighbourhood because there were more than eight people with HIV in her area. It was clear to the researcher that the woman’s perception about her diagnosis was changing: “I have been helped a lot as I no longer have a problem. I am now free since I can freely talk about this”.

Positive cognitive reframing was taught to assist her deal with her feelings of powerlessness, for instance: “you no longer feel guilty, as you know that it is not going to help you much – it is just going to make you feel powerless. It is important, of course, to decide how you will talk to them, because you already have this disease and you will not be able to change it. Of importance is how you perceive yourself. Move on with your life, instead of waiting for death and feeling powerless, because if death does not come soon you will be disappointed”. She confirmed this by noting that people come to see her because she models positive behaviour such as eating a balanced diet and looking after her physical appearance as before.

Further positive cognitive reframing was taught to help her deal with her feelings of guilt, for example: “do you then see that it will not help to feel guilty about the past, since others see you as their role model? Continue to perceive yourself in a positive way and attend the gatherings you are expected to as you live with this disease. Your life should go on”. Her assigned task for the next session was to determine in what way her level of confidence could be raised.

Comments: In this session positive cognitive reframing was effective in helping the client to start changing her negative perception about HIV and herself. This was evident when she stated that she had started speaking to her neighbours about her HIV status, despite having been scared of being discriminated against. For example: “therapy has helped me a lot because I am no longer scared and I am free indeed”. She appeared to be progressing well as a result of the assignment she was given as homework. She experiences the positive reaction of her different perception of HIV and disclosure – she sees that it is not bad but a relief. The positive experiences she had can lead to more positives.

Session 5

This session focused on how the woman experienced people’s reaction to her following her diagnosis and the disclosure of her HIV-positive status. Her assigned task was discussed and she stated: “I thought my confidence would be boosted by me not stressing, living a positive lifestyle and talking more often to others about this disease”. She also mentioned the conflict at home between her children which upsets her. The researcher taught her structuring behaviour technique that is setting rules to prevent conflict. For example, to deal with the

ongoing conflict among the children, she can draw up a timetable to alternate who uses the bathroom first so that no one gets favoured over the other. The rationale behind this advice was to encourage the participant to set goals that can realistically be attained to take control in the situation. She was encouraged to set small tasks, which gradually build up in complexity and difficulty (graded task assignment). She was taught coping strategies to manage her children and problem-solving skills to resolve their ongoing quarrels amongst themselves. She was advised to take control or charge of their situation because that will reduce her own levels of stress and will boost her confidence. She commented: “I am smiling ... because you are helping me a lot. I usually would be angry in dealing with such situations, especially with my children”.

Another issue was that she feels helpless when her son asks her money that she does not have. The researcher taught her assertiveness and social skills to deal with her son and others. For example: “it means that you are saying what you want to say to others in a polite and assertive way, only repeating it without raising your voice. If he called asking you for money, you could tell him that you do not have money and that you will deposit it into his bank account as soon as you have it”. She was shown that by saying it that way, she will be showing support to him without reminding him that she was not working, since he knew her current situation. If she was rude, she was told that she could negatively affect him and his studies. This technique was taught to help her to deal with the day-to-day problems she experienced relating to HIV/AIDS stigma and discrimination and how to handle her children.

A positive cognitive reframing of her relationship with her eldest son was also suggested, for example: “it is good that he is studying to acquire knowledge so as to be a professional one day. He is motivated to study, despite his home circumstances that are not easy”. The homework assigned for the next session was for her to practise being assertive, given that she handles situations by being rude.

Comments: She showed an understanding of the graded task assignment that was effective, as she mentioned: “what makes me happy is the fact that I am going to have a way of handling my children without making a big noise”. It was evident that the client was beginning to show an understanding of the coping strategies that proved to be effective, because she was accepting herself: “I can handle people discriminating against me and I know how to deal with their opinion about me”. Her homework assignment proved to be effective in changing her perceptions about herself, as she mentioned that she had started to live a positive lifestyle and talking more often to others about this disease to boost her confidence. It seemed, however, as if the positive cognitive reframing, assertiveness and social skills training, and problem-solving skills she had so far received made a difference to how she dealt with the day-to-day problems she encountered.

Session 6

The client said that she could not try being assertive with her daughter since she was away for the holiday period. Assertiveness and social skills training were repeated with the aim of further empowering her to handle her daughter. The woman complained that she did not know how to deal with her daughter, “I just look at her and avoid talking to her despite her attempts to talk to me”. She was advised to change her approach and start to respect her daughter, who could in turn respect her. As homework, she was tasked to reflect on how self-pity, isolation and neglect help her to cope because she thought that some of her daughter’s inappropriate behaviour was as a result of her HIV status. The rationale behind this assignment was to make her realise that her self-pity in reaction to her HIV-status would not assist her in dealing with stigma.

Comments: She appeared to be worried about her daughter’s inappropriate behaviour and the social skills she was taught gave her hope that she would be able to handle the girl. The assertiveness and social skills training was taught with the aim of enabling her to deal with her current difficulties. Although she did not do her homework assignment, she was hopeful that she could practise these skills as she commented: “... I am progressing well at the moment and I am still going to practise all that we talked about as soon as the schools re-open”.

Session 7

She realised that it would not help to pity herself. The focus of this session was on effective coping strategies because she was at some stage negative about herself. For example, the researcher reframed her problems positively by indicating: “it would help you to see the problems you are faced with as challenges, and not as punishment for bad behaviour. It does not mean that God is punishing you”.

The client was taught decatastrophising skills aimed at re-evaluating and modifying her catastrophic thoughts. She thought that disclosure of her status to her relatives would make her feel rejected and the researcher addressed this fear as follows: “people say bad things about people living with HIV/AIDS and it would help you to expect the worst. Thus, when the worst happens to you, it would mean that you were almost waiting for it”. She appeared to understand this line of thought. She had negative thoughts and regrets about not having taken work offers when it was offered to her directly after the diagnosis. She was helped to look for alternative explanations: “remember that you were not coping well at that time and you are feeling better now that you are in a situation where you are starting to look for employment”.

Assertiveness training was demonstrated once more, due to the fact that she indicated: “I have a partner who seemed to understand my position when we started to date. He is now telling me that he does not understand the issue of a

condom despite the fact that I told him that I am HIV positive”. She felt it is better to leave him. She was encouraged and equipped to be assertive: “it is important to tell him the importance of using a condom until he understands you and he will possibly see that you are determined and you mean what you are saying”. It appeared to be difficult for her to assert herself in this situation. She also had some misinformation about condom use which was cleared up.

A positive cognitive reframing of her relationship with the daughter who was troubling her was also suggested: “remember, it does not mean that your daughter is troubling you because of your status; this could be happening to any other person”. This further contributed to a positive perception of herself. Her task for the next therapy session was to imagine future difficulties and how to handle that.

Comments: It could be seen that the homework she was receiving at the end of therapy sessions contributed to a positive change in the way she perceived things and was effective in changing her behaviour, for example for her not to pity herself. Positive cognitive reframing proved to be effective as she showed good progress in terms of how she viewed her diagnosis because she said: “I feel that I am better since I have been empowered by you”. She seemed to be quite at ease with this technique that fit well into her perceptions. Coping strategies were effective in assisting her to cope, as she pointed out: “I am now feeling all right as you have assisted me to cope”. She did however seem to be battling with decatastrophising and asserting herself in handling her partner as she appeared to be giving up at times. However, she is not isolating herself since she even has an intimate relationship.

Session 8

The client’s homework was dealt with first during this final session. She stated: “if I happen to encounter difficulties such as the death of my son whom I trust so much, or maybe my house burning down, or me becoming too sick ... in that case there is nothing much I could do. I only have to accept the situation as it is and pray about it. I would need to avoid stress and deal with the problems since I am living with the virus”. Her future difficulties were positively reframed that she would regard all the difficulties she could come across, as challenges. Reframing was done to assist her in handling future problems she might come across more effectively.

She had negative thoughts, because she had a runny stomach that morning and was worried that she was going to die. The researcher asked her to record and monitor such negative thoughts and to replace it with alternative explanations such as: “...the fact that you had a runny stomach this morning does not necessarily mean that you are dying. It does however mean that you are faced with a sickness that you need to deal with”. These alternatives were shown to her until as many as possible were generated and she seemed to understand this

line of thought as she responded: "...I comforted myself by saying that I am still strong physically and cannot die". Decatastrophising was emphasised to further equip her to deal with her HIV-positive status: "it would help you to bear in mind that you could be sick at some stage; you may not be 100% fine because you live with the virus". Her response was: "yes, I was upset this morning when I had a runny stomach and vomited. I am now prepared to be forever ready when faced with situations like this one and I tell myself that I am not going to die since my time has not yet arrived".

Comments: The woman seemed to have improved as a result of the counselling she received, and hence therapy could be terminated. Her negative thoughts about how she viewed herself and how others perceived her for living with the disease had been changed through the method of positive cognitive reframing that worked well as she had different ways of looking at her diagnosis. Her homework assignments proved to be effective as she mentioned that she would learn to deal with the problems she comes across since living with the virus. Her behaviour had changed, as she started to accept her status, and she said: "I am now free, since I can talk to other people about HIV. I join other people if I see them sitting and I initiate conversation with them. In a nutshell, my life is pleasing". It is evident that the client initially found it difficult to grasp the coping strategies, but that she benefited greatly as therapy progressed. She was seen to be starting to change her perception of this disease and to be coping with stigmatising behaviour from others such as her neighbours whom she was scared of talking to about the disease. Decatastrophising was effective in making her aware of the worst that could happen in dealing with stigma. Identifying, challenging and changing underlying negative automatic thoughts and assumptions proved not to be very effective. This was perhaps due to the fact that too much information was said at a time and the client still needed to take it and think about it.

Overall discussion of participant 1

It appears as if a technique that worked well to produce change in the client's thinking and belief system was the identifying, challenging and changing underlying negative automatic thoughts and assumptions, such as that of her daughter's maladaptive behaviour that was to be blamed on her (the mother's) HIV status. This technique was effective because she did change her negative assumptions about HIV and relied on God in times of crisis. Teaching positive coping strategies also proved to be effective in assisting her to deal with others' discriminatory behaviours. Positive cognitive reframing, which empowered her to examine other ways of looking at her disease, which changed her behaviour, proved to be effective as she regarded HIV as similar to any other chronic disease. For instance, she used to think that her daughter does not respect her because of her HIV status.

Her homework assignments, which facilitated change during therapy proved to be effective in changing her behaviour. These assignments helped her to realise that there was no need to pity and isolate herself because of HIV but that she rather had to focus on living her “normal” life. Decatastrophising, a method of anticipating and dealing with negative thoughts was effective in preparing her for any future difficulties she might encounter. Assertiveness and social skills training proved to be effective in empowering her to handle her children and boyfriend. A graded task assignment was effective in changing her behaviour of shouting at her children, especially in the mornings. Problem-solving skills were effective in helping her manage her children too. All these cognitive behavioural therapy (CBT) strategies brought about emotional and behavioural change in the woman’s functioning. It could be pointed out that when this woman started to think differently about HIV, everything changed - as she could realise that she could seek employment, date and live her normal life.

The researcher felt that this was an interesting case as much change was observed also in the psychometric evaluation post-therapy, which strengthened the qualitative information. The findings indicate that the woman experienced less scores on depression (41 before which is extreme depression to 12 afterwards which is mild mood disturbance), less internalised stigma (46 before; 23 after), more positive ways of coping (38 before; 47 after) and her self-esteem (4 before; 0 after) scores improved after having participated in eight therapy sessions.

Participant 2

Session 1

1. Context

The second client or participant was a 38-year old HIV-positive woman, who received her ARVs from the Witbank Hospital and agreed to participate in the research. She was a single parent with one child and was unemployed. She lived with her mother, brother, child and sister’s children. She indicated that her partner had left her when she disclosed her status to him. Since her HIV diagnosis three years ago, she was suffering a low self-esteem and was angry at herself for contracting the virus. She said that she would never have sex again because she did not know from whom she got the virus. She knew that she contracted the virus through sex. She appeared to be blaming and criticising herself for contracting the virus. She dealt with the HIV diagnosis by isolating herself and her definition of HIV was that she had only a limited number of days to live – hence her chronic worries about death.

She disclosed her status to her immediate family who accepted her. Her extended family members were stated to discriminate against her in family gatherings. She said: “people discriminate against you when you live with this

disease, especially if you prepare food”. Their attitude further added to her loss of confidence and internalisation of stigma because she indicated that she would not cook for family gatherings because they would not eat her food. She denied reality by not thinking about the future, for example: “I was told at the clinic that I have this disease and I did not have to think about other negative thoughts for the future that would disturb me and I had to accept”. At times she seemed to be aware of the realities of living with the virus because she said: “...I know that my days are numbered ...” She tended to cope by keeping company with others, even if she did not disclose her status to them, and used distancing and distraction methods of coping, for example: “I am just visiting friends and talking to them ... whenever I think of this disease”. She used these avoidance coping methods whenever she was thinking of the virus and of dying soon.

2. Definition of the relationship with the therapist/researcher

She presented herself in a one down position and maintained that throughout the interview. She communicated in an uncertain and hesitant manner. Her tone of voice was low and she avoided eye contact during therapy sessions.

3. Distance (Punctuating from the participant’s point of view)

3.1 Acceptance of reflections

At times she denied reality through lack of response on her side and handled empathic reflections of her feelings in an evasive way. However, that changed to a more effective way of communication as therapy progressed. She avoided eye contact by looking downwards most of the time.

3.2 How did the client express herself?

She maintained distance by speaking in an intellectual way, thereby expressing less of her emotions. She presented herself as hopeless and blamed herself for contracting the virus. That is why she pointed out that she would never engage in sexual activity again.

3.3 Manoeuvres and behavioural patterns

A pattern of fluctuating distance was observed throughout the relationship. Manoeuvres for closeness were observed when she accepted reflections of feelings and manoeuvres for distance were observed when she spoke in an intellectual way.

4. The client’s support system

Her support system consisted of her mother, brother, child and sister’s children, who were supportive to her. Other family members were described in a distanced

manner because they discriminated against her, especially in family gatherings where she would cook. Their reaction further contributed to her internalising the stigma related to HIV/AIDS.

5. Hypothesis

She felt accepted by the immediate family, but rejected or negatively treated by the other family members. Her interactional style was to isolate herself from others. She had a low self-esteem and lacked assertiveness, which was further made worse by her feelings of internalised stigma that was strengthened by the enacted stigma experienced from her family members who did not want to eat her food. It can be noted that the association of HIV/AIDS with death also contributed to her feeling stigmatised, since HIV-positive people are often seen as “half dead” and death is not a subject that is openly discussed in many African cultures (Niehaus, 2006).

6. Symptoms

The woman experienced enacted stigma and tended to deal with it by withdrawing from family gatherings, therefore, the reactions of family members who discriminated against her confirmed her internalised stigma.

7. Goals of therapy

The main aim of therapy was to assist the woman to deal with the discriminatory reactions of others, as well as with her internalised stigma due to HIV/AIDS, which led to her self-isolation and low self-esteem.

8. Type(s) of intervention used and the reaction of the client

The client's negative perceptions about her diagnosis, which led to her withdrawal from others and not cooking in family gatherings, were challenged, and she was encouraged to look for alternative ways of thinking about her diagnosis (positive cognitive reframing). For example, the researcher remarked: “being HIV positive does not mean that you will infect others through the meals that you prepare. So learn to look at this situation in that way”. These strategies were suggested to help her deal with the internalised stigma she was experiencing and to assist her in handling relatives who refuse to eat her meals. She seemed to be battling to understand this information as it is contrary to what she believes she had to deal with, and this was not familiar to her, because she mentioned: “it is hard to look at things in that way”. A homework assignment was given to her, namely to reflect on what to do about the discrimination she was facing from the family members who did not want to eat meals she prepared.

Comments: The researcher cannot report much progress in therapy during session 1, because the woman did not express her emotions and was mainly

speaking in an intellectual way. CBT was introduced by challenging a central automatic thought and misconception about HIV (identifying, challenging and changing underlying negative automatic thoughts and assumptions). At this stage in therapy she was not ready to look for alternative ways of thinking.

Session 2

The participant's feelings of powerlessness and her homework task were dealt with in this session. She had to be reminded of the homework assignment and confirmed her original thought pattern by saying: "I would say that I would never ever cook if they cannot eat the food that I prepared". Her underlying assumptions, namely that she is transmitting the virus through preparing meals, were challenged with the aim of challenging the rules that guide her maladaptive behaviours (loss of confidence and internalisation of stigma, visible in not cooking at family gatherings because she is HIV positive). The researcher then asked: "how come that you are saying that you will not cook?" She responded: "the reason is that I am sick and they do not understand that I cannot transmit this (*HIV*) through food".

Her acceptance of their negative reaction was challenged: "it does not mean that you should no longer cook because you are being perceived as the person who can transmit this virus by preparing food ..." (Identifying, challenging and changing underlying negative automatic thoughts and assumptions.) She was then educated about the basic knowledge about HIV/AIDS, which contributed to her starting to gain insight, especially with regard to cooking for others. He said: "you know the truth that this disease is not transmitted through food. You get this disease in other ways".

A series of questions to identify underlying thought patterns was asked with the intention of assisting her to uncover the interpretations and evaluations that might contribute to her problems (Socratic questioning and reality testing). For example: "can I find out from you as to what happened in terms of cooking prior to your diagnosis... did you use to cook in family gatherings?" She indicated: "I used to cook then". In an attempt to refute her beliefs, the researcher pointed out: "and now that you are aware that you live with this disease, what prevents them from eating and/or stop you from cooking? So continue to cook". She responded: "I do get you".

A positive cognitive reframing was also suggested to assist her to alter negative perception of her diagnosis. For example: "you have been living well before you were diagnosed, so why must things change now that you have this virus? It is perhaps better to perceive your situation in a positive way as you are aware that you have the disease and you know what precautions to take where it is necessary". Her perception of her diagnosis was reframed further by mentioning: "what people do and say to you should not be seen to affect your confidence, but how you perceive it is important". She responded: "I would like to say thank you

that you give me lots of courage and strength to do all I wish to do”. Her homework assignment was to think of what she can do to keep or boost her level of confidence.

Comments: It was hard for her to start thinking differently in reaction to Socratic questioning and reality testing, and to work on homework assignments. It may take time for her to start altering her thoughts. She did however respond well to positive cognitive reframing and being challenged about her reaction to her family. This was achieved by changing her underlying assumptions about her relatives not eating her meals (identifying, challenging and changing underlying negative automatic thoughts and assumptions). For example, she remarked: “I am going to continue cooking and do whatever I want to do and what I have been doing before”. The knowledge she received about HIV transmission further appeared to give her insight about her disease, which helped to change her maladaptive behaviours.

Session 3

The client’s feelings of guilt, anger directed at herself, negative self-evaluation and the task assigned at the end of the previous session were explored in this third session. Her response to the assigned task was: “I need to share with other people if I have a problem in order to keep my confidence high. I also need to keep company of others and be happy with them. I need to keep myself busy, for example, I can sell goods, to avoid feeling bad and guilty”. Her guilt feelings were dealt with by means of positive cognitive reframing: “... note that how you perceive yourself is important as it can affect your confidence. That is important, as people often isolate themselves from others because they have this disease. You should visualise yourself accomplishing what you have planned, which can boost your confidence. Your diagnosis should not lower your confidence and you should still try to view yourself the way you were before you had this disease. Many things can still be accomplished if you see yourself in a positive light”. She responded by nodding her head. It was also clear that she dealt with her feelings of guilt by distancing herself from them and by looking for distraction and keeping the company of others whenever she experienced negative thoughts.

She was taught to identify negative automatic thoughts whenever she felt angry and evaluated herself in a negative way. For example: “... you do not have control over your thoughts, but you have control over how you perceive such thoughts. So learn to observe, record and monitor these thoughts. Negative thoughts may spontaneously come to your mind, but you have to deal with them. You need to be conscious of the fact that such thoughts can lower your self-confidence”. (Identifying, challenging and changing underlying negative automatic thoughts and assumptions.) The researcher challenged her negative thoughts further by making her aware that she did not experience guilt feelings before the diagnosis, why would she experience it now? She nodded her head and showed some understanding. Her negative feelings about living with the

disease were further reframed: “when you look at your diagnosis in a positive way, it will be important to realise that you have a chance to drink tablets, eat a proper or balanced diet and do all other things you were taught to do. That can possibly help to reduce your guilt feelings and you may end up living longer, rather than you pondering on negative thoughts that will not help you to cope”. Her homework for the next session was to monitor negative thoughts and beliefs that crossed her mind.

Comments: At this stage of therapy, the researcher was very active in the process of challenging and reframing but was uncertain whether the participant could deal with the information. She was not expressive of her emotions as she kept on responding by nodding her head. She also spoke about her diagnosis in an evasive and intellectual manner, and it was hard to get her involved in therapy. The researcher was therefore uncertain whether positive cognitive reframing, identifying, challenging and changing underlying negative automatic thoughts and assumptions made any difference to the way she perceived her diagnosis. Her homework assignment seemed to be effective as she had thought of ways to boost her confidence level.

Session 4

This session focused on her homework assignment and behavioural implications, since the client tended to pity herself for living with the virus.

She again did not remember what the homework assignment was and had to be reminded. She said: “when negative thoughts occur to me, I keep the company of friends ...” Her negative thoughts were explored: “what negative thoughts are occurring to you so that you would prefer to keep busy?” She expressed her negative thoughts: “I often think that I am sick. I often think of death . . . it is death that often crosses my mind. I then keep myself busy. I clean the house and listen to the radio”. A positive cognitive reframing was taught to help her look for alternative ways of thinking: “if negative thoughts and beliefs cross your mind, you need to have different ways of looking at them, since we are all anyway going to die in some way or other”. Her worries about death were challenged by asking if she was worried about death before she knew her status and why she was worrying now. A reframing of her worries about death was presented: “... so, take a positive view of these thoughts, as all of us will die and will not live forever. So live your life as you used to, continue to see your friends ...” She responded by laughing.

Through Socratic questioning and reality testing, she was showed positive ways of thinking. For instance: “if you are to be asked a question pertaining to the time that you are going to die, do you perhaps know when it is going to be?” She replied: “no, I do not know (*laughing*)”. The suggestions made by the researcher appeared to have brought some relief to her as she was starting to laugh during therapy. She was furthermore taught to question the evidence for her automatic

thoughts: “why should you stop doing other things and keep focused on death if you do not even know when is it coming? Use this opportunity to live, instead of pitying, neglecting and isolating yourself, and thinking about death. You have possibly not done anything wrong to contract the virus”. She replied: “no, I did not”. This maladaptive behaviour was addressed through positive cognitive reframing, aimed at changing her thinking. The researcher continued: “now, how come that you have low confidence, feel pity for yourself and think that you will no longer live when you are still living? See yourself as having a way forward and living because you have to live and celebrate before you die. You will not have a situation where you are living without the virus, because it is part of you and you have to live with it”. She admitted: “it is not going to help to pity myself”.

She was assigned a paradoxical homework task to reflect on how self-neglect, chronic thoughts about her worries and thinking of death would help her to cope. This assignment intended to make her to realise that negative behaviour will not help her to cope.

Comments: She had forgotten the homework assignment again and her response indicated that she coped with negative thoughts by not dealing with it but to distance herself from it. Although she is not expressive of her emotions and difficult to engage in therapy, towards the end of the session, it seemed as if she became more involved. During the session the therapist almost “bombarded” her with alternative ways of thinking, identifying, challenging and changing underlying negative automatic thoughts and assumptions, thereby overwhelming the client who was not involved in the process. It must however be stated that some change took place as she said self-pity will not help her to cope and she was starting to laugh. Therefore, it means that Socratic questioning and reality testing seemed to have brought some relief to the woman to question the evidence for her automatic thoughts about death.

Session 5

In response to her assigned task she admitted that thinking about death will not help her. It was stressed through positive cognitive reframing that she needs to focus on the things that will help her to keep going. She replied by saying: “I need to keep company of others and get joy from such, so that I should not think of any other thing that will disturb me”.

The fifth session focused on the participant’s experience of discrimination by her relatives and her lack of assertiveness in dealing with this matter. She was informed about anti-discriminatory laws that allow her to open a case against people who continue to discriminate against her or threaten to kill her because of this disease. The researcher also trained her to be assertive in dealing with people’s reaction towards her: “you cannot change the way people think and talk about it, but you can change the way you deal with what they say about you. In handling such people you just need to inform them that you are living with the

virus and that you cannot change that. In a polite and assertive manner without raising your voice and fighting them you say that to them again and again. You need to have a way of handling them because this will empower you to carry on with your life". Assertive behaviour was further role-played to her and she failed to demonstrate it back, and only showed agreement by nodding her head. She was required to practise being assertive in her home environment.

Comments: Her homework assignment proved to be effective as she noticed that thinking about death is not going to help her. Positive cognitive reframing about her diagnosis changed the way she thought of herself, namely: "I am better now ... I need to enjoy my life in general". This statement showed that the manner in which she perceived herself and her diagnosis had changed to become more positive. She struggled to grasp the assertiveness training technique when it was role-played to her and only nodded her head, possibly because it was still new to her and she was unfamiliar with it as it takes time to grasp the line of reasoning of the skill.

Session 6

She again needed to be reminded of her homework and replied: "I should talk properly to people even if they do not talk well with me (*coughing a lot*)". It was stressed that she needs to think of herself in a positive way even if others do not show respect. Seeing that she did not do her assigned task, assertiveness training had to be repeated as she appeared not to have developed this skill. She appeared to be agreeing by nodding her head. Positive cognitive reframing of negative thoughts on how to deal with others' reaction towards her was taught: "you cannot change the way they see you, but you can change the way you view yourself, even if they are negative towards you. Thinking about your situation in a positive way can keep you going despite what the people say". She once more responded by nodding her head.

Decatastrophising techniques were taught to assist her in dealing with people's negative comments: "you need to anticipate such talk - so do your best to educate those you can and those who decide to listen to you. However, do not expect to change all people's minds". She confirmed by replying: "you cannot change people's minds of course". Her relatives' reaction towards her was discussed further. She was requested to give her future plan for the next five to ten years, which was to be discussed in the next session.

Comments: In this session, the client appeared to be even less expressive of her emotions. The homework assignments did not bring about a difference in her situation, because she admitted to having forgotten to do them. The other CBT strategies such as positive cognitive reframing, assertiveness training and decatastrophising seemed not to have made a difference in her life, maybe because of her difficulty to grasp them and the fact that she was frequently admitted at hospital due to ill health. The other factors that might have

contributed to her not acquiring these techniques are that the researcher presented many strategies in one session and she seemed not to be involved enough. She perhaps needed some behavioural exercises or something more practical rather than just being involved on the cognitive level.

Session 7

Her assigned task to think about her future plans was dealt with first in this session: "I am planning to work somewhere and if I am not successful with that I plan to have a tuck shop. I am also prepared to bring up my child properly". She was encouraged to do something for herself that would help her not to worry about her disease. The client was taught positive cognitive reframing in order to assist her to change her stigmatising thoughts about HIV. HIV/AIDS was described to her in the same way as any other chronic disease, where people need to take medication and precautions, and not as a punishment, but a challenge.

The rest of the session was dealing with coping strategies and encouraging her to utilise the time she had left to accomplish her goals. Decatastrophising as a technique was again taught as it had not been acquired in the previous session. The researcher stated: "prepare yourself by expecting the worst, especially regarding bad comments you will receive from people. Thus, when the worst happens, you will be ready for it, as you have been waiting for it". She was encouraged to listen to radio programmes and read magazines about HIV, as well as to look at other HIV-positive people as role models. The homework assignment given to her was to imagine future difficulties and how to handle them.

Comments: In this session, she had attempted to do her assigned task, which appeared to have worked well for her. It seemed that a decatastrophising strategy that was suggested to her did not assist in equipping her to imagine the worst with regard to stigma, as she kept on nodding her head. Positive cognitive reframing and coping strategies also showed not to be effective as there was no movement or involvement from the client. She did not engage with the ideas that were suggested to her, therefore the researcher did not know what she understands.

Session 8

When discussing the homework assignment she said that she thought of the homework but was sick. She collapsed and was taken by an ambulance to the hospital where she was admitted. It could be noticed that the woman's condition was deteriorating, but she still attended therapy sessions.

The last session was spent repeating some techniques such as decatastrophising to help her deal with stigmatising reactions. Her response this

time was: “if they are rude to me ... I would report the matter to the police”. Anti-discriminatory laws were also emphasised to equip her to deal with discrimination. Teaching coping strategies such as taking care of her health and drinking her medication was stressed. She needed to explain her condition to her family so that they knew how to help her when she was sick. She was reminded that she may get sick at times, since her immune system is compromised, but that she needs to take care of herself. Therapy was terminated for this session even if the intended goals were not yet reached.

Comments: In this session, decatastrophising strategies and the knowledge she acquired when taught about anti-discriminatory laws enabled the client to confront and deal with the fears she had about discrimination. Teaching coping strategies equipped her to cope with her disease as she said: “I am feeling very well emotionally and I am fine”. Her homework assignment proved not to be effective as she did not do it possibly due to her ill health.

Overall discussion of participant 2

In a nutshell, the CBT strategies that did not seem to make much of an impact on the participant were the homework assignments, which she forgot. Assertiveness training was also not effective even if it was role-played to her. However, there were some change with regard to the woman thinking positively about her diagnosis and when she started seeing herself in a positive way, it changed her behaviour. She initially looked at things in a negative way, but her perceptions became more constructive afterwards, as she mentioned that she would continue to cook in family gatherings. Positive cognitive reframing about her diagnosis changed the way she thought of herself. For instance, she came to realise that worrying about death was not going to help her instead of living her normal life. It was noticed in this instance that her thinking was becoming positive. Socratic questioning and reality testing brought some impact to the client as she started to question the evidence for her automatic thoughts about death and was starting to laugh during therapy when the topic about death was discussed.

Her negative automatic thoughts about and perceptions of her diagnosis were challenged by changing her underlying assumptions about her relatives not eating her meals (identifying, challenging and changing underlying negative automatic thoughts and assumptions). This technique seemed to be successful, as she stated that she will continue to cook. The knowledge she received from the researcher about HIV transmission further gave her insight about dealing with her status, which assisted in changing her maladaptive behaviours - such as self-isolation because others were not eating her meals. Decatastrophising strategy was effective in assisting her to anticipate and deal with stigma she was experiencing, especially from her relatives. Coping strategies equipped her to manage her disease because she stated that if people discriminate against her she will report them to the police.

The difficulty in developing assertiveness training, role-play and some homework assignments could probably be related to her poor physical health. She was dealing with experiences related to her illness and was not emotionally involved in the therapy sessions. She expressed very little emotion and coped with her problems by not dealing with them, but by distracting herself from it by staying busy or keeping company with others. The illness could also have contributed to her poor cognitive functioning. Another factor that might have contributed was her low level of education, since she had only passed Grade 10. Other factors that might have contributed to her lack of reaction to the therapy could be that too many strategies were presented all at once – as such, the client was bombarded with lots of information. If only one or two were taught in a session, they might have facilitated change and have been more easily grasped. The researcher could have also been more creative by encouraging her to be engaged in interaction rather than to bombard her with words. The woman would have also benefited more in some behavioural exercises or something more practical rather than just being involved on the cognitive level.

Although it was difficult to engage this woman in therapy and understand her reactions, the psychometric evaluation that was conducted post-therapy to monitor changes in experiences and behaviour, confirmed that some change took place. These psychometric scores confirmed that she was experiencing less scores on depression (24 before which is moderate depression to 10 afterwards which is considered in the normal range), less internalised stigma (33 before; 27 after), more positive ways of coping (42 before; 47 after) and a higher level of self-esteem (13 before; 1 after) after participating in the eight therapy sessions. It is interesting to note that there was only a small change with regard to internalised stigma as was evident during the process of therapy.

Participant 3

Session 1

1. Context

An initial interview was conducted with a 36-year old HIV-positive woman at Witbank Hospital for the purpose of this research. She reported that she had lost her husband in 2004 due to HIV and that she had not been coping well since his death: “it is hard to know that I live with the virus ... I am not coping at the moment as I have seen my husband being sick until at the end. I even attempted suicide because I saw him suffering a lot”. Suicide had been on her mind since her diagnosis and she attempted to kill herself after being diagnosed.

The client had three children, 16, 14 and 12 years old, who lived with her. Her 14-year old son was also HIV positive and on treatment. She cried throughout the interview as she described her current situation and her son’s problems. Her main worry was what would happen to her son when she died. She pointed out

that her son was being discriminated against because his books were not marked by the teachers at school. The issue was reported to the child protection unit that intervened by speaking to the school principal.

The woman was unemployed at this stage and desired to get work. She indicated that she needed to eat a balanced diet whilst being on treatment. She no longer had parents as they were both deceased. She reported to be the last born in a family of eight children – three brothers and four sisters. She mentioned that she had disclosed her status to the in-laws and to her sisters and that she mainly received support from her third and fourth sisters. She had not disclosed her diagnosis to anyone else, because she feared being discriminated against.

The client reported that she felt stuck since her diagnosis and was not comfortable when among other people. She tended to isolate herself and pointed out: “I have lost weight ... and that keeps me indoors as I am scared of meeting people because of my weight loss”. She saw her future as dark and had lost self-confidence. She easily became irritated and angry, and was rude to her children since her diagnosis: “my first-born child was telling me that I am no longer the person they knew before this disease ...” She experienced anger as a result of this disease. She mentioned that she had no partner at the moment because she was living with this disease and had come from an abusive marriage. She said: “... I do not want to hear anything about intimacy at the moment”. She stated that she had been coping by praying, but she lost hope when her husband died and was worried that she was going to die like him.

2. Definition of the relationship with the counsellor/researcher

The woman entered the relationship in a one down position and mainly followed the instructions or the lead of the therapist. Her tone of voice was low and she maintained eye contact during the therapy sessions.

3. Distance (Punctuating from the participant’s point of view)

3.1 Acceptance of reflections

She maintained an appropriate distance in the therapeutic relationship by maintaining eye contact and talking in a congruent manner and accepting feelings that were reflected.

3.2 How did she express herself?

She was transparent and congruent when she spoke about her HIV status, especially when she talked about how her husband died as a result of the disease. She cried throughout the interview. She presented herself in a helpless, depressed manner and not in control of her current diagnosis. This could be

perceived as learned helplessness. She was also blaming herself for contracting the virus.

3.3 Manoeuvres and behavioural patterns

A closeness pattern was maintained throughout the therapy sessions. Manoeuvres for closeness were noticed when the client accepted reflections of feelings. She was manoeuvring for sympathy and assistance when crying throughout the session and talking in a defeated way. She seemed to over-generalise her diagnosis because she perceived her life as having ended due to HIV.

4. The client's support system

She had three children including her son who was also HIV positive and the victim of discrimination. She had three brothers and four sisters and described her relationship with two of her sisters as close because they were giving her the necessary moral support. Her financial support came from the government grant that her son was receiving.

5. Hypothesis

The woman felt scared, suicidal, depressed, helpless and hopeless because of her diagnosis. Her interactional style was one of self-isolation and thinking about herself in a defeated way, hence experiencing suicidal ideations. Her situation was exacerbated by the fact that her son was living with the virus and suffered rejection at school; thus she feared being stigmatised and discriminated against like he was. Her interactional style has a distancing effect as it isolated her from others. This was possibly depriving her of the support she could receive from them.

6. Symptoms

The client assumed that she would be rejected by others, which are the cognitive distortions that contributed to her symptoms. These distortions could be attributed to the fact that people living with HIV/AIDS are often judged to have brought the disease upon themselves by engaging in culturally prohibited behaviours such as sex work, drug use and sexual promiscuity (Bond et al., 2002). The result was that she tended to become depressed and to withdraw from others.

7. Goals of therapy

The aim of psychotherapy was to empower the woman to change her inappropriate style, namely her fear of discrimination, and to assist her to engage in social interaction and function optimally.

8. Type(s) of intervention used and the reaction of the participant

In this session, the participant spoke about herself in a negative way and said: "... I attempted to kill myself ... it does happen that I feel like killing myself, especially when I am alone and things are tough. I often ask myself why I am still living. As such, my life is stuck since I have this disease". She was assisted to look for the evidence that would refute her inappropriate beliefs and irrational thoughts which contributed to suicidal feelings as a result of her diagnosis. She perceived her diagnosis as follows: "it is hard to know that I live with the virus, as it means that it is the end of everything to me". Socratic questioning and reality testing was used to elicit the idiosyncratic thoughts that gave rise to her suicidal thoughts: "are you aware that you still have a reason for living? You mentioned that you have children to take care of. You also still have a family that needs you and you need to live for them". She appeared to be agreeing with this line of thought.

Positive cognitive reframing was taught to assist her in managing her diagnosis in a different way: "perhaps you need to look at this disease in a more positive way. Can you perhaps think of your children as a reason for living, as this can keep you going on with life?" She agreed by nodding her head. In view of her suicidal tendencies, she was assigned a task for homework, namely to find a reason for living. The rationale was that such a reason(s) would keep her going, even if it was tough, instead of having her ruminate on negative thoughts.

Reflections/Comments: Judging by the expression on her face, it seemed that she was emotionally relieved – possibly because she could talk and someone understood. It must be pointed out that Socratic questioning and reality testing and positive cognitive reframing were unfamiliar to her as she was noticed to be battling with these techniques. She was challenged by them to think differently about herself and the disease. She stated: "...it is hard for me. I cannot say I have any future, as it is not bright at all".

Session 2

Given the client's interactional style, this session focused on her feelings of powerlessness and the task assigned to her at the end of the previous session. In response to her assignment, she responded: "I have a reason for living. I will not kill myself now and I am not responsible for terminating my life, as it is the Creator's will that I should still live. Another reason for living is that I need to see my children grow up and I should give them all the love they deserve. If I encounter problems I would ask the Almighty to give me strength and courage, and live for the time that He has given me to live".

Her underlying assumption that HIV meant the end of life was challenged. The researcher purposefully challenged the rules that were governing her cognitive distortions (identifying, challenging and changing underlying negative automatic

thoughts and assumptions). She said: “you know when bad things happen to you, you get stuck. At the time I was diagnosed with this disease, the only thing that came to my mind was that this is the end”. This negative automatic association between HIV and death were reframed, since HIV does not mean death. Her response was: “of course, you are not dead; although, if you have a disease such as diabetes ... you are not discriminated against, but if you are HIV-positive, people discriminate against you ... if you live with this disease they would look for a glove, and that causes one to lose self-confidence”.

The researcher educated her about precautionary measures that she needed to adopt and emphasised that every disease has its own precautionary measures to adhere to. She needs to see this as protecting others and not as being discriminated against. She agreed by nodding her head. Positive cognitive reframing was taught to equip her to change her negative self-perception and how to perceive people’s remarks: “you cannot change what people say, but you can change the way you view yourself... such remarks might make you feel powerless and tap your confidence and self-worth, so you need to be careful of how you view yourself”. She confirmed by saying: “it is important for me to have a positive view of my situation and to have confidence in myself”.

Her negative automatic thoughts about life having come to an end were challenged by saying: “why would these thoughts then undermine your self-confidence?” Her response was: “you know when bad things happen to you, you get stuck ...” Her assignment for the next session was to ponder on how to boost her level of confidence.

Comments: The client started showing some hope that she might get help since she stated: “... I am better since I saw you last time. I feel that I am going to be helped that is why I would continue to come here”. It seems as if reframing contributed to a positive change about the way she thought of herself and perceived people’s remarks. Identifying, challenging and changing underlying negative automatic thoughts and assumptions seems to have given her some hope as she was starting to see some direction in life by saying: “... I now have to choose what I want in life”. Her homework assignment seemed to have made her aware of her reason for living.

Session 3

In response to the assignment, she responded that she has self-confidence and that she needs to get employment or sell something to earn a living and take care of her children. Her guilt feelings, which included anger and negative self-evaluation, were also discussed in this session. Her automatic thoughts (negative self-evaluation) were addressed as she was trained to consider alternative interpretations of her diagnosis: “if you pursue your planned goals, it will help you to appraise your situation in a positive way. The fact that you are living with the virus does not stop you from having a business; you should still be focused in life

as you used to be before you were diagnosed”. She was persuaded to proceed with her plans as it would not help her much to view herself negatively because of this disease.

She was further assisted to be positive towards herself through positive cognitive reframing: “learn to think in a more positive way so that if you experience negative thoughts, you can handle them. If you keep busy and focus on the things you are planning, you are able to appraise your situation in a positive way. Even if you have this disease, you can still manage to live and accomplish what you wanted to achieve”. She replied: “I am gaining more self-confidence as you are talking and I am starting to perceive things in a positive way”. She was tasked to monitor negative thoughts that often crossed her mind and to consider what to do to handle them.

Comments: It is in this session that the researcher felt and started to notice the participant changing her maladaptive way of thinking through reframing. This was noticed when she said: “... I am starting to perceive things in a more positive way. I do have issues that would at times frustrate me, but I would easily deal with them. That is why I am saying that I am gaining a lot from you”. It was perhaps starting to be easier for her to adopt positive cognitive reframing as a coping technique. It can be seen that when she started to think differently about HIV, everything changed – as she seemed to be determined to bring up her children. Her assignment appeared to have boosted her level of confidence.

Session 4

The focus point of this session was the homework assignment and her experience of discrimination by others, especially towards her son at school. She experienced a set back by wanting to kill herself and her children the previous Friday when the schools closed because her son was not coping well at school: “when I have to face all this, I experience all these negative thoughts and think of committing suicide”. The researcher challenged her thoughts: “how come that you want to kill yourself if your son is not coping at school?” She answered: “it is because I have tried a lot and it means he does not have a bright future because he is not coping at school”.

In this conversation the client was helped to identify the source of her negative automatic thoughts and suicidal feelings and other ways of thinking about her problems were identified. For example: “do you perhaps realise why you experience negative thoughts? Your child is not doing well at school and his homework is not marked, but you do not do much to address this. At the end of the day, you think that the situation is hopeless and death crosses your mind as a solution. How will dying help you then?” (Identifying, challenging and changing underlying negative automatic thoughts and assumptions.) She said: “I often tell myself that when I am dead I will not see and experience this pain that I have at all times. All will be over then”. The researcher further challenged her train of

thought that death will be the solution to her problems by making her aware that many other people will get hurt by her committing suicide instead of facing and dealing with her problems (problem-solving skills).

The researcher tried to assist her to deal with the problem in a more realistic way by recommending that her son is evaluated and get help with his school work. His lack of progress in school and the negative attitudes of teachers may not be related to his HIV status, though she associated it with discrimination. The researcher informed her about the anti-discriminatory laws that can protect her and her son and that he has the right to equal treatment in school. Assertiveness training was role-modelled to equip her to address her fear of being stigmatised and to help her son whom she thought was the victim of discrimination at school. The researcher advised her to talk to the child's teacher in an assertive way to respect her son as a person and to mark his books.

She said: "I sometimes think that life has totally changed to me in all aspects". Her negative thinking was challenged by saying: "did all these things seem to have changed before you were tested?" Her answer was: "no". These thoughts were further challenged: "how come that all things have changed now that you live with the disease? Why should things change now that you are HIV positive? Can you see that the manner in which you perceive your diagnosis affects your way of seeing things? Things will all look as if they have changed, even if they have not". She replied by nodding her head.

Coping strategies were taught in order to assist her to cope with the discrimination against her son. For instance: "can you think of other people who are HIV positive and are in the same situation as you? It could help you a lot if you were to join a support group to share experiences with others, because you are not the only one experiencing these problems". Her response was: "I have gained something today. I need to have a way of dealing with problems that I come across. I should not regard HIV as a disease that is going to kill me now, because it takes away the value of life. I have to regard this as a challenge. All the people on earth have problems but what is important, is how to deal with problems when you are faced with them".

Role-play was also used in therapy in preparation of a difficult homework task, which required her to monitor negative thoughts crossing her mind and to further practise thinking positively when faced with difficult situations. She was furthermore tasked to write a list of good things about herself so that if she had negative thoughts about herself, she can remember the good things about herself. She had to clarify the assigned task and the researcher emphasised that the assignment was aimed at preparing her to uncover positive aspects about herself (positive self-statement logs).

Comments: In this session, the client's style was discovered: she experienced her problems as huge and got overwhelmed by them, resulting in her not

addressing the problems but wanting to escape from them. I think that the client's eyes were opened that she cannot just run away from her problems, that she has to deal with them and that they are not all HIV-related. It therefore seemed as if she was gaining hope and realising that all problems were not related to her diagnosis. Despite her suicidal ideations, it could be seen that she was starting to think positive about herself. Although the rest of the CBT techniques seem to have contributed to making a difference in the way she thought of herself - the reason for these techniques not being grasped is probably that there were too many strategies presented at once, as she could have been given many statements and she still needed time to think about them. The researcher also thought that she felt overwhelmed by things and could not manage.

Session 5

This session dealt with the implications of her diagnosis for her behaviour, as well as the task assigned in the previous session. This is how she responded: "the good things about me are that I have children and I think they need me and I also love them. The second thing is that God loves me a lot. I also have a family that loves me and needs me. Lastly, I take care of others". It was clear that she was showing insight into the process of positive self-statement logs. Listing good things about herself rather than ruminating on negative thoughts about suicide was aimed at improving her low mood. The researcher strengthened her by saying: "even if it is tough, you can be positive and look at your strengths as a source or pillar of strength to you".

She identified her style of dealing with her negative thoughts by using distancing and distraction methods, which temporarily helped to reduce the strength of her suicidal thoughts: "when I experience negative thoughts, I try my best to deal with that by playing gospel music at a higher volume. Negative thoughts then go away. I also kneel down and pray if I experience negative thoughts. I sometimes go out for fresh air and then come back when I am fine. I will no longer have negative thoughts and I continue to do what I have been busy with". Her negative thoughts were explored when the researcher questioned: "so what is it that bothers you this much?" Her response was: "aah! It is death in most cases".

She was assisted to change her thinking by looking for alternative ways of thinking. For example: "you do not have to deny the fact that we are all going to die, but deal with it by accepting it and thinking about it in a different way. Death will come in its own good time, but go on with your plans". Positive cognitive reframing was further suggested when the researcher pointed out: "if you have a sickness such as a common cold that you had in the past ... you could be experiencing negative thoughts such as thinking about death. Deal with that by seeking medical help rather than pondering on negative thoughts". She again agreed by nodding her head.

She was made aware of the impact of negative thoughts in her life such as self-pity, isolation and suicidal thoughts. She was encouraged to think of the good things about herself (positive self-statement logs) and the advantages of knowing her HIV-status early on, since she can still have a chance of prolonging her life by adhering to treatment and taking care of her health. For example: “use your strengths to counter your negative thoughts and this would enable you to cope with fears of stigma and discrimination”. She answered: “... I am grateful for being equipped to handle these negative thoughts. I now know that if I am positive I could focus on good things and cope well. I would think of my children who give me a reason for living. I do not want to see these negative things as problems, but as challenges”.

The task assigned for the next session was to consider how self-pity, isolation, neglect and thinking about death would help her to cope, instead of living her “normal” life. This task was assigned in order to make her realise that her cognitive distortions are negatively influencing her behaviour and emotions.

Comments: It seemed as if the homework assignment had assisted her to uncover positive aspects about herself, instead of thinking about suicide. This suggests that the positive self-statement logs technique was effective. She appeared to be responding well to the positive cognitive reframing as she said, while laughing: “I am grateful that you have now shown me a positive way of thinking because I was negative towards myself. I need to change how I perceive things by not looking at myself as a person who is not going anywhere because of the virus. I still have a bright future and I have to work on my self-esteem in order to cope well. I have to take care of myself like I used to before I was diagnosed with this disease”. It could be seen that she was gaining insight in the process. Her faith in God also kept her going and gave her courage about living with the disease. Distancing and distraction methods temporarily helped to reduce the strength of her negative thoughts. She was assisted in evaluating such thoughts and enabled to modify her thinking, which may eventually change her behaviour.

Session 6

She did not do the homework, but responded that being negative and thinking about death would not help her to cope. The researcher stressed the value of positive thoughts: “... others would see you in a positive light and you would be able to accomplish your goals but if your thoughts are negative, most things would seem to be negative”. Her response was: “yes, I now understand you. I now realise that I have to see the problems I encounter as challenges. I need to have a way of dealing with challenges. Secondly, I do not have to pity myself and have low self-esteem. I have to proceed with my life and believe in myself. I also do not have to entertain negative thoughts. If I keep on thinking of death, I would become negative; I need to be positive in life and most good things would come my way”. It was evident that she was now familiar with the positive cognitive

reframing strategies as she seemed to be finding it easier to fit them into her perceptions. Thus, the researcher felt that her thought processes were changing. Positive cognitive reframing was further taught to address her uncertainties about the future: “your future may not be as bright as it can be, because of the way you look at it. If you were positive about yourself, you could pursue your dream of having a tuck-shop ...” She replied by nodding her head. For homework, she was asked to consider her future plans for the next five to ten years.

Comments: She appeared to be doing well in therapy as a result of positive cognitive reframing, since she said: “... whatever I used to be, that is, being sad and negative about myself, I no longer believe that way. I have now passed that stage and I can see that there is change in my life and that I am still going to live for my children”. It was evident in this session that positive cognitive reframing changed her negative way of looking at herself because of the positive way she spoke about herself. That had an impact in her functioning and helped her to start perceiving her diagnosis in a different way. She further remarked: “I now realise that I have to consider the problems I come across as challenges”. Her homework assignment seemed to have facilitated positive change and made her realise that her cognitive distortions such as forever thinking about death and pitying herself, were having a negative influence on her behaviour and emotions. For example: “... I do not have to feel pity and have low self-esteem. I have to proceed with my life and believe in myself”.

Session 7

When her homework task was discussed in this session, she responded as follows: “I want to be well physically and run a project that would help people deal with the stigma they have because of the disease. I need to take care of my children, buy a car and stay in a huge house. My main aim to run this project is to help other people who are HIV positive, including the orphans. I also want to generate an income from such projects”. Her response was explored further: “how far have you progressed in terms of empowering others who are HIV positive?” She answered: “I needed to be well first and accept my condition and then help others. I now have some information about the disease because I have started helping those who are closer by and I tell them about the disease”.

This session focused on educating the participant about the coping strategies required to assist her to further deal with internalised stigma and discrimination related to HIV/AIDS. For example: “helping others to cope would benefit you a lot, as you would in turn be helping yourself to cope. It would also help you to join support groups, specifically for people living with HIV/AIDS, so that it gives you a perspective that you are not the only person suffering from the disease. Use the time you are left with effectively to accomplish the goals you talked about ...” She seemed to be agreeing with this line of thought.

She was also trained to re-evaluate and modify catastrophic thoughts through decatastrophising. For example: “people might be rude about the disease and discriminate against you. If you anticipate that, it would be easier to cope, because you were prepared for it”. Her response was: “I have learnt that I have to love myself since I am attending therapy, it does not mean that I am going to die tomorrow”. The participant was asked to imagine future difficulties and how to deal with them - that was done with an aim of empowering her to deal with real difficulties she might come across.

Comments: She really benefited from the coping strategies as it was clear from her remark: “HIV is like my friend because I live with it and wherever I am, it is part of me”. This could be seen as a complete mind shift from being passive to taking control of her situation. The homework assignment appeared to be effective in changing her suicidal thoughts because she seemed hopeful about living and had plans in place. Decatastrophising served to modify her irrational fears of being stigmatised to positive beliefs. It can be noticed that she came from being suicidal and running away from problems to dealing with issues and wanting to help others. This change could have been brought about by the change in her thought processes that made it possible for her to start coping and dealing with stigma.

Session 8

In reaction to her homework assignment to imagine future difficulties and how to handle these, she responded that she will “be strong and not lose courage in order to achieve all future plans. I also need to look at problems as challenges and not be easily discouraged by all that comes my way. I should not allow the problems that I am faced with to discourage me and I should try to solve them”. The decatastrophising technique and coping strategies were repeated in this final session before termination of therapy in order to assist her to deal with future problems: “if you have some minor illness, it would help you not to focus on dying but on seeking professional help. You would be different in terms of how you approach your day, as you would tend to be more positive in your thinking and you would have responded and handled your situation well”. This strategy focuses on taking care for you minor problems and not to think it is the end of the world.

Positive cognitive reframing was also recapped in order to further enhance the participant’s coping and assist her to think positively. For example: “if you view your illness in a negative way, you would end up feeling negative about yourself. So learn to think more positively in order to live a positive lifestyle”. She reacted: “...I must admit that there are obstacles that I am faced with and I regard them as challenges, but not as problems”.

Comments: It was in this last session that the researcher realised that the client had acquired some coping strategies, as was clear from her response: “I now

have my dreams, plans, goals and life in place. Everything is fine with me. I must face the HIV I have. I am now going to live for my children as you have helped me a lot. My life is now back to normal functioning and I would like to thank you for all you have contributed in making me feel better”. The homework assignment showed to be effective in changing her perception of handling problems: “... I will solve problems whenever I am faced with them”. Positive reframing proved to be effective in altering her negative thinking as she said: “I have confidence that I would be able to overcome what I come across”. Not much could be inferred about the decatastrophising technique because she only responded by saying: “yes”.

Overall discussion of participant 3

Overall, it was observed that the homework assignments were the strategies that contributed to a significant change in the way that this client perceived stigma and they assisted her to uncover positive aspects about herself, instead of thinking about suicide. Strategies to identify, challenge and change underlying negative automatic thoughts and assumptions assisted her to identify and monitor her negative and suicidal thoughts. The positive self-statement logs technique was effective in enabling the participant to realise that she still deserved credit for living. She responded well to the positive cognitive reframing: “I am grateful that you have now shown me a positive way of thinking because I was negative towards myself. I need to change how I perceive things by not looking at myself as a person who is not going anywhere because of the virus”. It was clear that she had gained insight into the process.

Problem-solving skills which were taught made a huge positive impact on how she dealt with her diagnosis, as she regarded problems as challenges. Teaching coping strategies assisted her to cope and alter her thoughts because she stated that she would take care of herself like she used to before she was diagnosed with this disease. Distancing and distraction methods temporarily helped to reduce the strength of her suicidal thoughts – she was assisted to evaluate such thoughts and that enabled her to modify her thinking, which changed her behaviour. Decatastrophising technique played a significant role to modifying her irrational fears of being stigmatised to positive beliefs.

The fact that many strategies were taught in one session (instead of only one or two that could make a positive impact) could have overwhelmed her. This was possibly the reason why Socratic questioning and reality testing techniques, and assertiveness training that was role-modelled seemed not to have contributed much to making a difference to the way she thought of herself and why she took longer to understand some techniques. The other reason was that she was unfamiliar with these techniques, as she stated: “... it is hard for me ...” The researcher could have also given her lots of information of which she needed to think about, before implementing it. Change will thus not be immediately observable.

It could be seen that the intervention model was effective in this case because this participant felt better equipped to deal with her daily problems and had some hope for the future compared to her negative perceptions and suicidal thoughts at the beginning of therapy. The psychometric evaluation that was conducted post-therapy to monitor changes in experiences and behaviour confirmed these findings as the client experienced less scores on depression (48 before which can be interpreted as extreme depression to 18 afterwards which is mild mood disturbance), less internalised stigma (38 before; 26 after) and better positive ways of coping (32 before; 43 after) as well as a higher level of self-esteem (11 before; 0 after) after participating in therapy.

Participant 4

Session 1

1. Context

The participant was a 40-year old married woman who was seen at Witbank Hospital and was referred by the nurses for the purpose of this research. She was seen in order to be assisted to deal with internalised stigma and discrimination. She had three children to whom she had not disclosed her status. She suspected that they knew about her being infected with HIV, because they saw her taking medication regularly. Her husband was also HIV positive and on treatment. She was living with her husband and lastborn child. At the time of the initial therapy session, she was in her fourth month of taking antiretroviral drugs. She reported that her mother was deceased and she was distant to her father who had married another woman. She had brothers and a sister and mentioned that she had disclosed her status to her sister who was a source of support to her and escorted her to receive treatment at the hospital. She stated that she had also disclosed her HIV status to one colleague at work. She furthermore indicated having been epileptic for the past 18 years and that she was on treatment.

She pointed out that she found it difficult to cope with people's bad comments about people living with HIV/AIDS like herself. Thus it was evident that she was experiencing internalised stigma and feared discrimination. She reported to be feeling sad following her diagnosis almost a year ago. She blamed herself and had plenty of regrets about contracting the virus: "... I was hurt to know that I have contracted this virus ... I was deeply wounded because I have been behaving well in my marriage, fearing to contract this HIV, but it did not help at all. It would have been better if I had misbehaved, but I had not". She kept on wondering how she had contracted the virus and had anger directed towards her husband for having cheated on her. She said: "I asked him if he is the one who infected me, since I do not have multiple partners. I was so angry because of that".

She appeared worried about how other people would perceive her with regard to her diagnosis, especially her children and brothers. She was experiencing suicidal ideations and coped through praying, as she pointed out that her future depended on God. She stated that her diagnosis had brought her closer to God, especially at the time when she was sick and bedridden, using a wheelchair to move around. She denied reality by not thinking about this disease. For example: “I do not think about that but I say to myself, I do not care about it since I have given all to God – He will defeat this disease as long as I am on regular treatment”.

2. Definition of the relationship with the counsellor/researcher

The participant presented herself in a helpless, depressed and in a one down position. The relationship continued in that manner throughout the different therapy sessions.

3. Distance (Punctuating from the client’s point of view)

3.1 Acceptance of reflections

The participant maintained an appropriate distance throughout the relationship by keeping eye contact and she accepted empathic reflections of feelings.

3.2 How did she express herself?

She spoke about her HIV diagnosis in a helpless yet congruent way. She was blaming herself and her husband a lot for contracting the virus, as she indicated that she had been well behaved in her marriage.

3.3 Manoeuvres and behavioural patterns

A pattern of closeness was maintained throughout the relationship. She was manoeuvring for closeness, assistance and support while she gave details about her HIV status, especially when she spoke about how shocked she was to realise that she was living with the virus.

4. The client’s support system

Her support system comprised of her husband and three children. She received most support from her sister to whom she had disclosed her status and who escorted her to the hospital for treatment.

5. Hypothesis

It could be hypothesised in this instance that she felt rejected because she had internalised stigma that made her sensitive to others’ remarks about the disease.

She felt angry towards her husband and her relationship with him was not close. Her interactional style had the effect of distancing and isolating her from others and made it difficult for her to disclose her status to them.

6. Symptoms

The woman preferred to isolate and reject herself and not to disclose her status to others because of her fear of being stigmatised. This maladaptive behaviour possibly deprived her of the potential support she could be receiving from others by talking about her status.

7. Goals of therapy

The aim of CBT was to assist the participant to realise the impact of her inappropriate style (that is, blaming herself for contracting the virus) and coping with people's negative comments about HIV. In addition, therapy would aim to help her deal with the negative relationship with her husband, who could be a valuable source of support to her.

8. Type(s) of intervention used and the reaction of the client

This woman had negative perceptions about HIV in this first session: "...I have been hearing people saying that HIV-positive women like men. I also heard that on the radio stations and television when they were talking about this disease, but I kept on asking myself how come, because I do not have multiple sexual partners". The researcher challenged her automatic thoughts and self-perception with the aim of changing her thinking (identifying, challenging and changing negative automatic thoughts and assumptions). For instance: "were you thinking about yourself this way before knowing that you contracted the virus?" She reacted: "no". Her negative thoughts were further challenged: "now, how come that you perceive yourself as a person who likes men?" Her answer was: "because people see it that way".

Her negative perception about people's bad comments when living with HIV was modified through positive cognitive reframing: "it is not necessarily true that HIV-positive women like men, as you are saying that you behaved yourself well since your childhood and you do not have multiple partners". She was tasked to think about how to cope with people's bad remarks regarding being HIV positive. This assignment was given to her as homework because people's stigmatising connotations seemed to be stressing her: "I hear people talking and mentioning people's names, those suffering from AIDS and that hurt me most, and I become quiet".

Comments: It must be noted that not much of a change was noticed after this session, as this was the initial session and the concept of cognitive behavioural therapy was still new to her and she was not used to this way of thinking. As a

result, positive cognitive reframing technique and identifying, challenging and changing negative automatic thoughts and assumptions did not yet make a difference in her life.

Session 2

This session focused on the participant's feelings of powerlessness, as well as on the assigned task. When asked about her homework, she stated that she does not experience much stigma, since people seem to understand the disease better and that she copes with it by disregarding people's negative comments. Her negative automatic thoughts about people's negative remarks were cognitively reframed by looking for different ways of perceiving such talk: "what people say is not necessarily true. It is important to realise that you cannot change how other people see this disease, but you can change how you perceive it".

Positive cognitive reframing was furthermore taught to assist her in handling negative comments: "people's bad comments should not necessarily make you feel powerless. Of importance is how you perceive yourself and not how they perceive you. So, it could help a lot if you are thinking positively about this situation. These people who are making negative remarks might not even know their status. Look at it in this way that you are better, because you are aware of your status as you have been tested and you know what to do now that you live with the virus". She responded: "people are rude to me about this while they could be in the same situation as I. I am in a better position because I know about my status and I know what to do, especially when it comes to treatment". She was then tasked to reflect on how to keep her level of confidence up since it appeared to be low.

Comments: She showed some progress in therapy, as she said: "I do not have problems now as I heard you talking ... I am proud because I am receiving treatment". It was clear in this instance that positive cognitive reframing offered her hope that she could start changing her thinking. The homework task that had been assigned for the second session did not make an impact in changing her thinking because she could have thought about it and forgot it in the week.

Session 3

The task assigned after session 2 was discussed and she responded: "I am managing to boost my confidence level with regard to HIV because I have decided that I will not allow myself to be controlled by this disease but I have to control it by taking medication. I am a child of God and I also trust in God. I am taking care of myself and I hope that He will help me to fight this disease if I continue to take treatment well. I am also prepared for people's bad comments because I do not easily get scared by this disease. What also boosts my confidence is the fact that I know about my status. I believe that you do not invite

this disease to come into your life but you realise that you have contracted it and you cannot do anything about it”. Based on what she said, it could be noticed that she was starting to have a more positive view of people living with HIV/AIDS.

The participant’s feelings of guilt were dealt with in this session. She was feeling guilty and regretful that despite her good behaviour she still contracted the virus. Positive cognitive reframing was taught to assist her deal with her guilt feelings: “it is important to look at your diagnosis in a positive way, as you know that you did not invite this disease into your life. If you perceive it in a negative way, you will end up feeling guilty and that is not going to help you”.

She was further encouraged to consider alternative reasons for interpreting her diagnosis in a different way. For instance: “you still have a reason to live because you have children to take care of and you still need to go to work. You still have to teach others about the disease in order to combat the spread of HIV and to empower them to deal with stigma and discrimination. You will tend to evaluate yourself in a negative way and have guilt feelings if you do not actively become involved in empowering others. And how will guilt feelings help you?” Her response was: “that is not going to help me”.

She was also taught the signs and symptoms of this disease, which stressed that she still has a long time to live and that there are still many things she can accomplish rather than thinking that it is over. She replied: “I will go and talk to others informing them that they need to urgently seek professional help if HIV/AIDS signs develop”. Her assignment was to monitor negative thoughts and beliefs that crossed her mind and to consider what steps to take when faced with them.

Comments: Her homework assignment was effective as it assisted her to have a positive way of perceiving HIV/AIDS. She seemed to be reacting well as a result of being informed about the signs and symptoms of HIV/AIDS, because she acknowledged to be learning a lot. It is at this stage of therapy the participant indicated that she was starting to talk about the disease by disclosing her status to her children, brothers and sisters, and community members. It could be noticed that she was not upset about people’s comments: “... I am also prepared for the people’s bad comments”. Considering alternative reasons for interpreting her diagnosis in a more positive way that was taught through positive cognitive reframing was also effective as she felt empowered to look at her disease in a different way. Her trust in God also gave her courage and strength in dealing with her disease.

Session 4

The participant’s assigned task was explored and she reacted: “...if negative thoughts come to my mind, I console myself that I am on treatment. I need to protect myself by eating well and using a condom. I also need to regard myself

like others as I am accepted by people”. It could be seen that she was starting to perceive herself in a positive way. The session focused on the implications that the client’s diagnosis held for her behaviour such as her self-isolation and self-pity for living with the disease. Her negative thoughts were as follows: “...it is when I think that I do not look like others ...” She was assisted to deal with such negative thinking through positive self-statement logs: “it would help you a lot to focus your attention on writing a list of good things about yourself when you experience negative thoughts – rather than ruminating on them”.

Positive cognitive reframing was taught to assist her deal with her negative thoughts about not being similar to others because of HIV. The researcher remarked that “... people feel pity for themselves because of the virus and tend to neglect and isolate themselves. That results in them thinking in a negative way and they end up experiencing suicidal thoughts, which tend to affect their psychological wellbeing. Adopting a positive attitude helps you not to think much of suicide”. She seemed to understand this line of thought.

Some coping strategies were presented to help her cope with her diagnosis in a different way: “the disease is part of you and it should be regarded as your friend, as it will only die in your body once you are dead”. She also agreed with these suggestions. She was given a homework assignment, which involved the practise of cognitive behavioural techniques, to reflect on how self-pity, isolation, neglect and suicidal thoughts would help her to cope. In addition, she was tasked to consider how denial of living with this disease would help her cope. These tasks were given to make her realise that such behaviours would not help her cope.

Comments: The homework assignment was effective as it enabled her to feel better and have steps to utilise when faced with negative thoughts about thinking that she does not look like others because of her status. She remarked: “I was happy to realise that I still look like others when I was welcomed well at work. When I think that I do not look like others, I always say to myself that that is not the case ...” The client regarding herself to be like others brought about the change process. At this stage, the participant showed to be familiar with positive cognitive reframing and coping strategies, as they showed to be effective in helping her to handle people’s comments. She stated: “I am feeling better. I am enthusiastic and ready for anything that one can say. I do not care how bad people are talking about others or those living with the disease”. Positive self-statement logs did not prove to be very effective, as she merely responded: “yes” when informed about it.

Session 5

Her previously assigned tasks were discussed and she responded: “pitying and isolating oneself is not going to help me at all, because I did not invite this disease into my life and I have done nothing wrong. I have to continue with my

life by taking my tablets well so that I may live for my children”. From these statements, it could be noticed that she was accepting her diagnosis in a positive way.

Due to the discrimination that HIV-positive people face, this session focused on dealing with the reaction of others. Assertiveness and social skills training were taught to equip her to deal with possible discrimination against her as she was living with the virus. This included teaching her about anti-discriminatory laws. She had started talking about the virus at work and to other family members so as to assert herself in her environment: “you can seek help from anti-discriminatory laws if you are talking to people who are rude to you and threaten to kill you, such laws will protect you from being harassed. You need to know that you should address people in a polite and assertive way. By being assertive means that you say one thing several times without being rude to others”. Her response was: “okay” and she asked if white people were not going to look at her in a funny way and discriminate against her especially if she had to handle their food.

Her negative perception that she might be discriminated against at work was dealt with by showing her alternative ways of thinking about it: “...you may not change people’s perception about the disease, you can change the way you view yourself. Do not think that you may do nothing now that you live with the virus and that you may no longer handle people’s food”. Decatastrophising was taught to assist her in dealing with the reaction of others once she had started to talk about the virus to others: “people may not be as polite and understanding to you, so you need to anticipate their bad remarks by expecting anything from them. You must know how to handle them when you encounter such comments”. She replied: “it is good that I know of the disease, because I have to teach others about the signs and help prevent them from dying soon”.

She was taught a number of coping strategies aimed at handling people’s negative comments and the stigmatising connotations of living with the virus. For instance: “if people are rude to you, you could respond by saying ‘I never chose to live with the virus. However, I have changed my life by thinking positively, eating a balanced diet, adhering to treatment regimen and using a condom when engaging in sexual activity in order to live longer.’” Her response was: “I am happy that I know about my status because if I did not know, I would have long died of the disease without knowing about it”. She was tasked to practise assertiveness and social skills as her homework.

Comments: She seemed to be doing well with regard to the positive cognitive reframing technique maybe because she was now familiar with this method and could fit it into her perception. She indicated: “I am now proud of who I am and I do not even mind if people laugh at me”. In this session, it became evident that she was now able to handle people’s negative comments as she felt that others’ reactions were not important any more – it could be noted that the shift in her

thinking also brought about the change process. Coping strategies about handling people's negative comments showed to be effective in assisting her to deal with such talk. Her homework assignment was effective as it helped her realise that self-pity and isolation would not help her to cope: "... I am now knowledgeable about handling some circumstances about my disease". Not much could be said about assertiveness and social skills training, or about decatastrophising, as they did not make an impact with regard to changing her thinking and behaviour.

Session 6

The effect of the task that was assigned to the client, namely to practise assertiveness, was explored. This is how she reacted: "I practised being polite when speaking to people and respecting them. I do not have to pity myself or have low confidence. At times it happens to me, but I feel that I am still similar to other people. I need to respect people even if they insult and shout at me. I still have to be assertive in handling them, so that we end up talking well to each other". It could be seen in this instance that the homework assignment had a positive impact on her perceptions of herself.

The participant's uncertainty about the future was discussed in this session and the assertiveness training was further consolidated: "if you assert yourself in your environment and talk well to others, it would help you to reduce your stress level. You do not need to be stressed up by people's remarks, but you need to have a way of managing such talk. When you are polite and assertive, it would help you to cope and not be discouraged about your future since you know what your goal is". She replied by saying: "when I come across a person who is HIV positive like me, I would need to exercise patience and talk well to that person, since I am a role model to him/her. I know that that is how I felt, although I am now fine, since I know about my status".

Decatastrophising was taught once more to help her deal with people's stigmatising behaviours: "you need to prepare yourself for the worst with regard to people's remarks so that when you talk to them, you will be forewarned that people may not be as polite and accepting as you hope them to be. If you develop a more adaptive and functional way of coping by expecting any kind of comment with regard to stigma and discrimination from them, it might help you to cope". Her response was: "people are also accepting and respecting me when I talk to them. The way you have taught me helps me to be less stressed and I am being accepted well by most people". For her assignment, she was required to consider her future plans for the next five to ten years in order to further facilitate change and progress between sessions.

Comments: The assertiveness training which was conducted as her homework was effective in enabling her to assert herself in her environment: "... I have been empowered to assert myself and I thought that I am worthless, but the

counselling I received helped me to function appropriately”. She was apparently starting to grasp decatastrophising techniques, which assisted her in dealing with stigma: “I am able to feel free and talk to others about the disease when I meet them. I tell them that to live with the disease should not be seen as disappointing since one never had a choice in contracting it. What is pleasing me is that I have now accepted myself and that people respect me. I am now much improved, unlike before”. The fact that the participant had accepted living with the virus facilitated the change process.

Session 7

Her homework assignment was dealt with in this penultimate session. Her response was: “my plan would be to take care of myself and give a better future to my children if God would still give me a chance to live. My wish is to help the people who are sick like me, because I could not walk”. It could be seen in this instance that the homework assignments she had received and had completed successfully facilitated change as therapy progressed.

The researcher encouraged her to say more about her future plans by nodding his head and she continued: “I want people to notice that HIV-positive people can get better by getting treatment. Even if you live with it, you become better, you live longer and you are not dying. I have seen that happening in my life – that is why I want to help my family, children, grandchildren and the community to have a brighter future. I can see people looking at me suspiciously and I tell them that it is of course like that (*referring to being HIV positive*). Then it becomes my duty to empower such people to cope with the disease”.

This session was dedicated to teaching coping strategies so as to assist the woman in dealing with stigmatising behaviour from others. Emphasis was placed on her assisting others to cope by talking about the disease and joining support groups to share her experiences with others. She was further encouraged to see other people as role models and look up to them for dealing with internalised stigma and the discrimination. She was furthermore reminded that it is normal to experience setbacks. Her response was: “I just want to say that I am going to live longer”. Her homework assignment for the last session was to imagine future difficulties and how to handle them.

Comments: She appeared to have gained from her homework assignments as well as coping strategies at this stage because she said: “I am prepared to help others because I can see that there is light at the end of the tunnel. I am no longer ashamed of who I am now. I live a normal life like any other person and I do not regard myself to be different from others. That helps me to experience less stress and not to think a lot about this disease. I also want to be a role model and be brave enough to tell others what to do”.

Session 8

The participant's homework task was dealt with and it was given in preparation of the difficulties she might come across regarding stigma and discrimination. She commented: "I would say that I need to exercise patience in all aspects. Even if there are people who say bad things and discriminate against me I have to be patient and know how to handle them. I would advise those people living with the disease on what to do in order to live longer and tell them to practise a positive lifestyle like I do".

Coping strategies were recapped in this session to further remind her of ways of coping. For example: "see your diagnosis in this way – you are better off because you know about your status and you know what to do in terms of thinking positively, taking your tablets, engaging in safe sex and eating a balanced diet". Her response was: "I have now accepted that I am living with the disease. I do not care how other people talk about the disease because I am now better and safe from acquiring the disease any more. I know how to take my treatment, which further helps me to cope".

Comments: She seemed to be understanding some coping strategies she was taught and these helped her deal with the stigmatising behaviour from others, as she indicated: "I have improved a lot because I did not know where I was going before ... I work with confidence because I know about my status and I know what to do since I live with the virus. My future is now brighter and I have to think of it in a much more positive way. I need to educate my children, family and others so that they should be safe from contracting the virus and cope well with it if they already have it". Her homework assignment was effective as it had helped her to adopt a positive lifestyle and to deal with stigma. For example: "I would like to say that I am now grateful that I know about my status, regardless of what people would say".

Overall discussion of participant 4

To summarise, the strategies that contributed to a significant change in the way she dealt with stigmatising behaviours from others were the homework assignments that were successfully completed. They clearly facilitated change as therapy progressed. Teaching coping strategies about handling people's negative comments were effective in assisting her to change her negative thinking about the virus. For example: "I have now accepted that I am living with the disease. I do not care how other people talk about the disease because I am now better ...". Positive cognitive reframing also proved to be effective in altering the participant's negative thinking about the virus. For instance: "I am ready for anything that one can say. I do not care how bad people are talking about others or those living with the disease". The assertiveness training that was taught was effective in enabling her to assert herself in her environment. For example: "... I have been empowered to assert myself and to function appropriately".

The decatastrophising skills taught, assisted to prepare her in dealing with stigmatising connotations from others. Being informed about the disease, in particular the signs and symptoms of HIV/AIDS worked well in giving her knowledge about her disease. That helped her to be knowledgeable when speaking to others. It could be seen that when this client started to think differently about peoples' stigmatising connotations, everything changed as she could see herself as a role model and started to talk to others about her disease.

Techniques for identifying, challenging and changing negative automatic thoughts and assumptions, as well as for positive self-statement logs did not make much of the difference in her life, possibly because they were administered early in therapy and the participant was not yet familiar with these techniques. As a result, these techniques could perhaps have been presented later as therapy progressed. At this stage therapy was terminated, given her ability to do self-change and her being better equipped to deal with stigma and discrimination. The intervention model played a significant role in assisting this woman to deal with stigmatising behaviours from others.

Her post-therapy psychometric assessments that monitored changes in her experience and behaviour showed that she had improved well as a result of the intervention. These findings were corroborated when the client experienced less scores on depression (13 before which is mild mood disturbance to 4 afterwards which is normal range), less internalised stigma (27 before; 19 after), more positive ways of coping (37 before; 42 after), and higher self-esteem (13 before; 0 after) after participating in therapy.

Participant 5

Session 1

1. Context

The participant is a 26-year old female who was seen at Witbank Hospital's Wellness Clinic. The aim was to assist her to cope with internalised stigma and the discrimination she was faced with. She was referred for therapy by the nursing sisters at the clinic and had been diagnosed as HIV-positive seven months prior to the start of this study. She reported having been on treatment for six months by the time the research commenced. She had a three-month old boy who had been tested for HIV, and they were awaiting the results. Although she had her own (reconstruction and development programme (RDP)) house, she had been living with her parents, four sisters, brother and son since the recent birth of the latter, seeing that it was a culturally accepted practise for a woman who had just given birth to stay with her parents. She admitted to have been scared following her HIV diagnosis, as she said: "I even locked myself in my room avoiding any form of contact with others". She also stated that she was

scared about facing death sooner: “it scares me to know that I am going to die soon”.

She appeared to be worried about what would happen to her child if she died, because she had since parted ways with the father of her son. She showed anger towards males seeing that she said: “I fell pregnant and I parted ways with him ... I did not want to talk to males afterwards”. She currently had a boyfriend who did not know about her HIV diagnosis. She reported experiencing guilt feelings when engaging in sex, as she stated: “I get scared when we are supposed to engage in sexual activity ...” Her current boyfriend was said to be refusing to use a condom. The client indicated that she had only disclosed her status to her sister and to a friend who was also HIV positive. Her friend accompanied her to the clinic for treatment. Those were the only two people cited to be offering her moral support since they knew about her diagnosis.

2. Definition of the relationship with the counsellor/researcher

She entered the relationship in a one down position and maintained that throughout the interview. Her tone of voice was low and she maintained eye contact during the process of therapy.

3. Distance (Punctuating from the participant's point of view)

3.1 Acceptance of reflections

The interview started with a distance between interviewer and client because she spoke about her disease in an intellectual way. This gradually changed as the interview progressed to an appropriate distance, seeing that she was accepting reflections of her feelings.

3.2 How did she express herself?

She initially spoke about her HIV diagnosis in an intellectual way and expressed very little of her emotions. She was blaming others for contracting the virus and did not take responsibility for dealing with the stigma she was faced with. By blaming others, she appeared to have an external locus of control.

3.3 Manoeuvres and behavioural patterns

A pattern of fluctuating distance was noted throughout the interviews. The participant manoeuvred for closeness when she accepted reflections of feelings and manoeuvred for distance when she spoke about her diagnosis in an intellectual way.

4. The client's support system

Her support system comprised of parents, four sisters, brother and her child. She had not disclosed her status to any of them (except one sister), including her boyfriend, because of fear of being discriminated against.

5. Hypothesis

In many African communities HIV/AIDS is associated with death, moral judgement, religious punishment and a failure to follow cultural traditions (Aggleton & Chase, 2001; Bond et al., 2002; ICRW, 2002c; Kopelman, 2002; Niehaus, 2006). It is under such circumstances that this woman was scared about living with the virus, and therefore the thought of dying soon made her feel uncomfortable. Her interactional style was one of self-isolation. It had the effect of distancing and isolating her from others. She thought of herself in a defeated way, and feared disclosing her status to others because she was scared of being stigmatised and discriminated against. It could be hypothesised in this instance that she was over-generalising her situation. She was also depriving herself of the moral support she could be receiving from family and others if she were to disclose her status to them. Her self-isolation and lack of disclosure possibly gave her temporary peace of mind.

6. Symptoms

The participant was apparently scared about dying soon and living with the virus. Thus, she isolated herself from others because she couldn't face the stigmatising connotations and discrimination related to HIV/AIDS.

7. Goals of therapy

The aim of psychotherapy was to enable her to deal with internalised stigma and discrimination due to HIV/AIDS, which caused her to withdraw and isolate herself, and to be scared of living with the virus.

8. Type(s) of intervention used and the reaction of the client

The woman's fear of death became evident in this session as she said: "... it scares me to know that I am soon going to die". She was assisted to think about her prognosis in a positive way through positive cognitive reframing: "it would help if you try to look at death in a positive way. At least you are now on treatment for this disease and you are going to live longer if you adhere to it; unlike someone who has not been tested and does not take her medication". She appeared to be battling to understand this strategy, perhaps because she was not familiar with this way of thinking, as she said: "it is hard to see it in that way". The homework assignment that was given to her was that she should find a

reason for living. Thus, even if she got scared about the possibility of dying sooner, she would have that reason to keep her going.

Comments: At this early stage of therapy, the researcher could not say much about the effects of the intervention of the day. It was not easy for her to incorporate positive cognitive reframing into her perception.

Session 2

This session aimed at exploring the participant's feelings of powerlessness, which included her lowered self-esteem and self-worth. Her homework assignment was explored and she reacted: "... I want to live so that I can bring up my child. Secondly, I need to see my grandchildren. Thirdly, I want to live longer so that I should find my purpose in life". She further explained that she wanted to see her child growing and going to school, and getting educated to become what he wants to be and have children that she should bring up.

The researcher taught positive cognitive reframing when he emphasised that it helps to have a reason(s) for living because it gives direction that also helps to accomplishing goals. She was furthermore assisted to look at her diagnosis in a positive way. For instance: "even if you have negative thoughts and feel bad on a particular day, you have a reason for living because you want to see your child growing up. If you do not have such plans you will end up experiencing more negative thoughts". She seemed to agree with this line of thought and stated to have a problem with her boyfriend who did not want to use a condom, which caused conflict in their relationship.

She was questioned about when she planned to inform him about her diagnosis and she indicated that she was not prepared to tell him because she thought he is not a matured person with whom she can live with in future. She was shown alternative ways of interpreting her situation through positive cognitive reframing of negative automatic thoughts (that is, thinking she might lose him if she discloses her status). The researcher suggested: "please remember that he might still insist that you do not use a condom because he is possibly not suspecting that you live with this disease. It is clear on your side, but not to him. To him the condom is about trust and to you it is about preventing the spread of HIV".

She was shown the advantages and disadvantages of disclosing her status to him: "disclosing your status to him can make him understand why you need to use a condom. You should be aware that it is not going to be easy to do that. You should possibly have disclosed your status when you started to date, so that he could also have engaged in a relationship where he knew about your HIV status. He could have anger directed towards you if he finds out about your status, feeling that you are putting his life at risk. He might also appreciate the

fact that you have told him. Otherwise what would be the other reason for using a condom?” She seemed to be agreeing by nodding her head.

In order to assist her to deal with her fears about disclosing her status, a decatastrophising technique was taught to modify her fears and to make her aware that they were not so terrible after all. For instance: “your boyfriend might part ways with you if he finds out about your disease - that is his decision, of course, and anticipate it. Other people, whom you thought might not know about your disease, might end up knowing”. Role-play was demonstrated in order to modify her intermediate and core beliefs about disclosing her status. For example: “can you think of a situation where you did not have the disease and your boyfriend had it and did not disclose his status to you? How would you feel about it?” She reacted by laughing and said: “I would accept him because I love him. I would go for testing so that I should know about my status and so that we can go ahead with the affair”. Her homework was to consider how to raise her level of confidence, as this appeared to have been lowered.

Comments: Her initial homework assignment seemed to have been effective in assisting her to be hopeful and finding a reason for living. It must be noted that the participant did not express much of her emotions as she spoke about her HIV/AIDS diagnosis in an intellectual way, indicating that she was still struggling to grasp the strategies that were taught. Thus, not much could be stated about her progress in therapy and about the effects of the rest of the CBT strategies, as she merely responded by nodding her head and saying: “yes”. Apparently the positive cognitive reframing, role-play, decatastrophising, advantages and disadvantages did not make a difference – maybe because there were too many strategies that were presented at once. As a result, the researcher could have bombarded her with lots of information and she possibly needed to think about it first. The researcher also felt that she could react to a challenge of her fears but could not be able to do self-change.

Session 3

Her homework assignment was discussed and she responded: “my confidence is boosted by things that I do. I am on treatment and I trust that the more I adhere to it, the longer I will live”. A positive cognitive reframing technique was taught about treatment adherence and an emphasis was placed on speaking positively about herself. She appeared to be agreeing with the suggested statements. In this session, the participant’s guilt feelings were explored. She had indicated that she felt guilty when she was about to engage in sexual activities, because she had not yet disclosed her status to her partner and was finding it difficult to do so.

She was taught assertiveness and social skills through role-playing in order to be equipped for disclosing her status to the partner. For instance: “you could have disclosed to him at the time he was talking of being scared of many diseases such as AIDS. You could have said at that stage that, that is the reason why I

want us to talk, because you could contract it because I am already living with it. That is why I say we need to continue using a condom to protect you from getting the disease”. She appeared to be struggling to understand and implement this skill in her life, as it was unfamiliar to her, because she only nodded her head and said: “yes”. Decatastrophising technique was further taught to assist her to anticipate the worst and to realise the benefits she could derive from disclosing her status. In this instance, she was shown that her guilt feelings could be stemming from non-disclosure.

Assertiveness training was again taught with the aim of assisting her to disclose her status to the boyfriend. For example: “you need to assert yourself in this situation and tell him”. She answered by saying: “I told him that he should remember about this disease and that if a person is infected, it does not show. I gave an example by saying that he does not even know if I live with the disease or not. He did not comment. I am thinking that I should not tell him and that we should part ways, because he causes me not to be sure of my standpoint”.

Her underlying assumption that she would lose her boyfriend if she disclosed her diagnosis to him was challenged: “are you ready for parting ways with him?” Her response was: “it is tough as I am not able to end the affair... eish (*showing some disappointment*)”. She was shown the advantages and disadvantages of disclosing her status, for instance, if she told him, he could be grateful that he was informed, or he could be angry that she did not disclose at the beginning (which she should have done). Her homework was to monitor all the negative thoughts that worried her and to think of what to do about disclosing her status to her partner. He probably did not want to listen to her when she asked to speak to him.

Comments: She showed progress in gaining assertiveness skills, which had been presented through role-play, because she had indicated that she told him that they need to adhere to condom use because of diseases that are there. Her homework assignment proved to be effective as she stated that her confidence is enhanced by regularly adhering to treatment. Positive cognitive reframing, decatastrophising, advantages and disadvantages, and identifying, challenging and changing negative automatic thoughts and assumptions did not prove to be very effective – maybe because she was receiving lots of information at once and that was perhaps unfamiliar to her. The client was also not much involved in therapy.

Session 4

Due to the stigma and discrimination that an HIV-positive person faces, the implications that her diagnosis held for her behaviour were discussed. Her homework assignment was explored in this session and she indicated that she becomes angry because her son’s father does not support him and that she becomes jealous to see him with another lady. The client was taught problem-

solving skills by being shown an option of filing for maintenance and her response was: “I have not done much on that, and he is failing to maintain him. I have to use the R820 grant that I receive to cater for all the child’s needs”.

When speaking about her ex-boyfriend she stated that she has parted ways with him, but wished all sort of bad things to happen to the lady he was dating – that she could be knocked down by a car and die. Her negative thoughts for wishing others dead were challenged: “are you aware that those are just your wishes and they may perhaps not be the way you want them to be?” and her response was that it was because of the anger she had towards him. Her negative thoughts were further challenged by the researcher: “that is why you need to go and monitor all these negative thoughts so that you should do something about them. You would want her to be knocked down by a car and that seems not to be happening as you wish”. (Identifying, challenging and changing negative automatic thoughts and assumptions.) Her answer was: “that is where the problem lies”.

She was trained to consider alternative interpretations of her current situation and to look at it in a different way. For example: “it possibly means that at the time you parted ways with him, you were still in love with him. Perhaps your involvement with your current boyfriend started because you were trying to cover up as you were feeling lonely. That is possibly why you quarrel about most of the issues and you wish you could part ways with the current boyfriend, because you are still attracted to the former boyfriend. If you really want to part ways with him you can still arrange that he sees the child in your absence”. Her response was: “I sometimes get confused, because he says he has moved on, but he still monitors me because of being jealous”.

Socratic questioning and reality testing was taught to help modify her negative thinking and her confusion about her ex-boyfriend. For instance, through questioning, she was shown to take a decision that would help her to handle her confusion better to avoid being stressed. She responded: “... you further asked me to think of all the negative thoughts that cross my mind and what to do when I experience that? I often pray that God should help me to deal with these bad spirits”. Some coping strategies were taught when the researcher said: “it is good to pray about your difficulties, but you still need to take a specific action by addressing the problem that might help alleviate your experiencing of negative thoughts”.

She was further taught to look at alternative ways of dealing with her unresolved conflicts: “addressing issues would possibly help you not to feel self-pity, and not to isolate and neglect yourself. You possibly have more negative thoughts because of unresolved issues with your boyfriends. How would it help you to feel jealous of your ex-boyfriend?” Her response was: “it won’t help me”. The researcher further said: “it is of course not going to help you, so find a plan or a way of addressing these difficulties”. Her homework assignment was to reflect on

how self-pity, isolation, neglect and thinking about death would enable her cope. This task was given to make her notice that these maladaptive behaviours have no significance in helping her cope. When asked if she was progressing well as a result of therapy, she replied by saying: “yes”.

Comments: She reacted well to the previous homework assignment as she was able to learn to identify thoughts that were disturbing her behaviour – that is anger, lack of financial support for her son and unresolved conflicts with partners. The rest of the techniques (positive cognitive reframing, teaching coping strategies, problem-solving skills, Socratic questioning and reality testing, identifying, challenging and changing negative automatic thoughts and assumptions) showed not to be that effective. These techniques were perhaps too difficult for her and it could be that the researcher did not know how to involve her in therapy. It could also be noticed that the client had several social problems from her past and current relationships that overwhelmed her and that she was not prepared to take action to deal with them.

Session 5

Due to her fear of stigma, the session focused on her dealing with the reaction of others. On her assigned task, she reported that it would assist her to keep company of many people and to keep herself busy by doing window shopping so as to think less of many negative thoughts. She further indicated that she has to accept her disease and accept that she has parted ways with the father of her child and he has moved on and she has to move on with life. She also thought that she has to get employed so that she could think less about her current situation. It could be seen in this instance that she was using distancing and distraction methods to cope with her negative thoughts.

She was assisted through positive cognitive reframing to substitute negative core beliefs for positive ones. For instance: “you have to develop a way of dealing with the underlying assumptions by counteracting all the negative thoughts that cross your mind. If you have negative thoughts about death, you need to counter it or think of it in a more positive way such as that it is okay to think of death and that all of us are going to die at some stage”. Positive cognitive reframing was furthermore taught to enable her to deal with her fears of death by thinking of illnesses she experienced in a positive way and see them as challenges she was faced with for that day. By doing so, her focus would not be on the negative thoughts.

When asked about issues of concern that she wanted to raise during therapy, the woman mentioned that she was still experiencing problems with her current boyfriend who had extra affairs. His aunt was also involved in their quarrels and accused her of not showing respect towards him since she terminated the affair. The client appeared to be lacking assertiveness in terms of handling her boyfriend and his family and was therefore trained to assert herself using a role-

play technique. For example: “you do not have to listen to all the people who are making bad remarks, but you need to have a way of handling them to avoid being stressed up. Being assertive means that you still respect his sister and aunt and you do not become rude and fight with them. You talk to them like I am speaking to you now”. Her response was: “... yesterday I quarrelled with my sister who is pregnant. She was swearing at me in the same manner as my boyfriend’s sister and aunt. She reminded me that I live with the disease and that she hates me”. The researcher trained her further to be assertive in dealing with her sister.

Some coping strategies were taught to assist her to cope with her sister’s discriminatory behaviour. For example: “it will be fine if you keep calm so that she is just talking on her own. You seem to have been important to her at that time, since she would be following you. She might end up appearing to be a fool because she is talking on her own without you responding much to her”. She replied: “I think she has a problem because she was telling me how useless I am as an HIV-positive person and that I can die at any time”.

Problem-solving skills were taught: “there are anti-discriminatory laws to protect you from being discriminated against. If you address the issue through your parents, they should be of help to you or you could refer your sister for psychological assistance. If that fails, you could open a case of discrimination against her”. She responded by nodding her head, which possibly implied that she understood this line of thought. Her assigned task was to practise being assertive in her interaction with others.

Comments: She used distancing and distraction methods to help her to get some distance from her negative thinking about the disease and that appeared to be temporarily effective for her. She seemed to be progressing well with regard to the homework assignments she was receiving because they showed to be effective in changing her negative thinking to positive thinking. The researcher must state that it was difficult to talk about the difference that other techniques made, as she only nodded her head and said: “yes”. As a result, it was hard to measure the impact of the coping strategies, problem-solving skills, positive cognitive reframing as well as assertiveness training using role-play. The researcher felt that she could have been engaged more in behavioural exercises other than on a cognitive level.

Session 6

The participant’s uncertainty about the future as well as her homework assignment was explored in this session. On her assigned tasks, she stated that she thinks all things could go well if she can learn to be polite and speak well to people. She mentioned to have practised that with her boyfriend and his family. For example: “I told his sister that if she wants to talk to me she should speak well and not swear at me. She told me that the family loves me and would like

me to be their daughter-in-law and if I say that I no longer want their child that hurts them and that she would come with other family members on Saturday to speak to me at home". She further pointed out that her boyfriend and family realised their mistakes in that meeting and asked for forgiveness, and that things have started afresh and she has forgiven him too and the affair is going on.

Assertiveness training was again taught to assist her to further grasp this technique and to disclose her status to her boyfriend, for example: "so, it has helped you to assert yourself in your environment because you were able to say what you wanted to say to his family, since they managed to listen to you after you told them your preferences? It is in this same way that you still have to talk to him about your status". Decatastrophising was presented with an aim of preparing her to deal with her fears of disclosure: "anticipate the worst when you disclose your status to him. Thus, if the worst happens such as being rejected by him, you would have been waiting for it – as long as you would have said what you wanted to say to him all along. Informing him would perhaps help you to be less worried and not to feel guilty during sex, because you are probably scared that you might infect him". Her homework task was to consider her future plans for the next five to ten years and to further think about how to disclose her status to her partner.

Comments: She appeared to have acquired assertiveness techniques that were taught as her homework assignments and could fit these techniques into her lifestyle, as she mentioned that things could go well if she can learn to assert herself in her environment. In this case, she probably realised that her partner was not listening to her because she speaks to him in a rough way. It was still difficult for her to disclose her status to her boyfriend despite being taught decatastrophising strategies to prepare her for the worst (in terms of dealing with possible fears of stigma). As a result, decatastrophising was not effective in changing her negative perception of being discriminated against if she discloses. That was noticed when she did not comment much when taught about decatastrophising as she merely responded: "yes".

Session 7

Her homework assignment for this session was explored and she said that she would be pleased to get work and be married. She further indicated that she would like to stay with her son and husband in a big house and drive her own car. The other thing that she mentioned was that she ended up disclosing her status to her boyfriend who had promised to undergo testing whenever he had time. She said he did not show any funny behaviour and she even told him that she was on ARVs. He was then reported to seem to understand why she was insisting on using a condom and was grateful that he was told.

This session was devoted to coping strategies in an endeavour to assist the participant to cope with her fear of stigma. For example: "it is good that you

ultimately managed to disclose your status because you would not feel guilty when it comes to sex. I would recommend that you inform others as time go on, so that they can learn from you about how to cope with this disease”. She was encouraged that it would also help to see other HIV-positive people as role models in order to cope like them.

A positive cognitive reframing technique was also taught to enable her to think in a positive way: “to be HIV positive does not necessarily mean that you have been awarded a death certificate and that you are dying tomorrow. Do not regard yourself as a person who is useless because you still have plans to accomplish. If, however, you perceive yourself in a more positive way, others would perceive you in a positive way as well”. Her fears about stigma were further re-evaluated and modified through the technique of decatastrophising. For example: “it would benefit you to prepare yourself for the worst, so that when you come across difficulties in disclosing your status to others, you should be ready for them. Whatever comes your way, learn to deal with it”. She seemed to be agreeing by nodding her head. Her assignment for this session was to visualise future difficulties and how to cope with them.

Comments: She showed signs of acquiring decatastrophising techniques, which resulted in her changing her negative thinking about stigma, because she ended up disclosing her status to him. This technique changed her attitude towards anticipating the worst and thinking positively, because she ultimately managed to disclose her status, which she feared doing all along. Her homework assignment and positive cognitive reframing facilitated change as it assisted her to think about the future in a positive way, as she hopes to be married one day. She responded by nodding her head when the coping strategies were taught, thus making it difficult to judge whether these therapeutic skills were effective or not.

Session 8

The participant’s homework assignment was explored and she responded: “what I thought about is, what would happen if my boyfriend is HIV positive because he still has to undergo testing? I am still waiting for my child’s results too and if all these people are found to be HIV positive, it would mean that it is the three of us who would be living with the disease”. The researcher explored that scenario further when he stated: “so what are you going to do?” She answered that she needs to disclose her status to other people at home because it is only her sister, friend and boyfriend who knew about her status. The idea of disclosing would be that they should be able to help them. It could be noticed that the participant now perceived her diagnosis in a more positive way.

Decatastrophising techniques were recapped to help her deal with the worst things she could come across in life: “by imagining future difficulties, it means that you are preparing yourself for the worst. Thus, when you come across these difficulties, you will be equipped to handle them”. Coping strategies were

repeated in this session to further empower her to cope. For instance: “you need to disclose your status to your family so that they may be able to assist you to cope with this disease. If, for instance, you disclose your status to your mother, she could be the one to take over the upbringing of your child, should you happen to die”.

Positive cognitive reframing was taught: “if you take a positive view of the future difficulties that you are imagining, you would realise that if the three of you are living with the disease, you would have learnt of it at an earlier stage when you can still look after your health. Your boyfriend and son would then have an option of receiving treatment as soon as possible and that would help to prolong their lives. They would learn to deal with the stigma and discrimination as you would be their role model since you are now starting to cope with this disease”.

Comments: When asked about how she was coping at this stage of therapy, she replied: “I am progressing very well and I am feeling well”. It could be noticed that she was now starting to cope with her diagnosis as a result of the coping strategies she received. Her homework assignment to visualise future difficulties and how to cope with them proved to be effective in this session, as she was convinced about disclosing her status to others. She responded by only nodding her head to the positive cognitive reframing and decatastrophising techniques she received, making it difficult for the researcher to say if these techniques actually worked.

Overall discussion of participant 5

Although she seemed to be struggling to familiarise herself with the strategies at the beginning of therapy, a change was seen towards the end of therapy because she was starting to disclose her status to others – the main thing that she initially was scared of doing. The researcher can also point out that when she started to think differently about HIV – that is, accepting her status and disclosing to her boyfriend, things started to change. That suggested that the coping strategies she were taught could have been effective. It was clear that the skills of assertiveness that were taught through role-play empowered her to deal with her partner. The problem-solving skills assisted her to handle the difficulties she experienced with her boyfriend and his family. Positive cognitive reframing showed her alternative ways of appraising her situation, which helped to change her perception about the disease. She appeared to have acquired decatastrophising technique which assisted her to change her negative thinking about the fear of stigma, as the skill started the change process by enabling her to anticipate the worst coming to disclosure of her status to her boyfriend.

She carried out her homework assignments, which facilitated change as they assisted her to think in a positive way about the future. Distancing and distraction methods helped her to get some distance from her negative thinking about the disease, as she kept herself busy by doing window shopping not to think many

negative thoughts. These techniques worked specifically with this participant. They were taught in the form of homework assignments and she completed most of them by taking some time to think about them at home.

Techniques that seemed not to be that effective were Socratic questioning and reality testing, advantages and disadvantages, identifying, challenging and changing negative automatic thoughts and assumptions. This was maybe due to the fact that too many strategies were taught at once and perhaps they were unfamiliar to her. In order to help her to grasp what was done in therapy earlier, the researcher should perhaps have presented one or two strategies at a time, given her level of education (she had only passed grade eleven). The researcher could have also been more creative by using behavioural skills in addition to cognitive techniques.

The change observed by the researcher was confirmed by the psychometric evaluation post-therapy, which strengthened the qualitative information. The findings indicate that the woman experienced less scores on depression (17 before which is mild mood disturbance to 8 afterwards which is considered in the normal range), less internalised stigma (32 before; 21 after), less negative ways of coping (30 before; 26 after) as well as more positive ways of coping (38 before; 41 after) after having participated in eight therapy sessions.

Participant 6

Session 1

1. Context

The participant was a 27-year old female who was seen at the Wellness Clinic for the purposes of this research. She was a single parent with two children and she reported that her 12-year-old son was disrespectful and troublesome. She lived with her mother, siblings and her children. She indicated to have been emotionally disturbed and scared of dying following her HIV diagnosis. She said: "I am deeply hurt by the diagnosis because I sometimes think that I am going to die tomorrow". She ended up isolating herself, feeling angry and she did not want to talk to people. Her idea of an HIV-positive person was that such a person is very sick and cannot do anything.

She pointed out that she was experiencing suicidal thoughts when she encountered difficulties. She indicated that: "... I then wish that I could have long died ...". Her partner died due to HIV/AIDS in 2004. She thought that she was also going to die soon, and therefore she considered suicide. She was experiencing stigma and discrimination related to HIV/AIDS because she stated: "... people know that I live with this disease and that is why I experience suicidal thoughts. I feel this way as a result of people treating me in a funny way". The people she was referring to were relatives, immediate family members and

community members who were aware of her status. Her diagnosis was a shock to her, because she had thought that the disease could only be contracted by people who have multiple sexual partners. She felt sorry for herself following her diagnosis. She perceived her future negatively, for example: “my future is not bright at all, because whatever I have planned to achieve in life, which is to work and live a normal life, I will not, because I no longer regard myself to be similar to others”.

She stated that her family knew about her HIV status and that her sister, who was a social worker, accepted her. However, her mother was really discriminating against her: “she would not take care of me even if I was very sick”. Her sister, neighbour and aunt, who is a nurse, would instead take care of her when sick. She cried throughout the session as she spoke about how she was being rejected by her family because of HIV. It was evident in this research as noted by the researcher that some women in the country are still experiencing stigma related to HIV/AIDS as this participant explained it. Her father was mentioned to be supportive to her, although he did not live with her. She also stated that her siblings were supportive.

She had disclosed her status to other people in the community and they upset her by showing pity and feeling sorry for her. She said: “the more they feel sorry for me, the more they make me not to cope. All that I need from them is support, not for them to feel pity for me, as that causes me not to cope well”. She reported to be coping by ignoring people’s negative comments and putting her trust in God.

2. Definition of the relationship with the counsellor/researcher

The participant entered the relationship in a one down position and she maintained that throughout all therapy sessions. She maintained eye contact most of the time and her tone of voice was low and soft.

3. Distance (Punctuating from the client’s point of view)

3.1 Acceptance of reflections

The client maintained an appropriate distance in the relationship. This was done by maintaining eye contact and talking about her HIV status in a congruent manner and accepting reflections of feelings.

3.2 How did she express herself?

She cried throughout this session and spoke about her diagnosis in a transparent and congruent way. She explained all about her disease. She presented herself in a hopeless and helpless way, and out of control of her diagnosis. She was also blaming herself for having contracted the virus.

3.3 Manoeuvres and behavioural patterns

A pattern of closeness was maintained throughout the therapeutic relationship. That was evident when the participant accepted reflections of feelings. She was manoeuvring for assistance throughout the session when she spoke about her diagnosis in a defeated and hopeless way.

4. The client's support system

Her support system consisted of her sister, aunt and father who were offering her moral support. Her relationship with her mother was characterised by conflict and she felt rejected and discriminated against by her. Her relationship with her 12-year-old son was described as symmetrical because of the ongoing conflicts due to the son's disrespectful behaviour. She also mentioned that she did receive support from her other siblings or her other child.

5. Hypothesis

The stigma she was encountering caused her to experience depression and suicidal thoughts, and she felt rejected by her closer primary family system (that is, particularly her mother). She subsequently tended to withdraw from others because she felt worthless. Her interactional style had the effect of distancing her from others; it took away her desire for life and caused her to experience suicidal ideations.

6. Symptoms

Due to the fear of being discriminated against by the people to whom she had disclosed her status, the woman tended to feel depressed and worthless. She thought of herself as already dead and therefore felt suicidal. She also considered herself different from others because of the virus.

7. Goals of therapy

The aim of psychotherapy was to equip the participant to deal with her cognitive distortions of feeling suicidal and worthless so as to function and interact optimally in her environment.

8. Type(s) of intervention used and the reaction of the client

Her negative automatic thoughts were challenged since she was negative about herself. She stated that, since she was diagnosed with HIV, she no longer looked like others. The researcher challenged these negative thoughts by saying: "how come?" Her response was: "because of my disease". Her thoughts were further challenged: "were you thinking of yourself this way before you were diagnosed?" and her answer were: "no". The researcher further stated: "how come that you

are no longer similar to others now that you are HIV positive?” She replied by nodding her head.

A positive cognitive reframing of her negative automatic thoughts about her dying sooner because of the virus was taught. This was to assist her in considering alternative ways of looking at her diagnosis: “are you aware of the fact that we are all going to die at some stage and that you need to live and enjoy life to the fullest while still living?” Her response was: “yes, I never thought of it that way”. Given her suicidal tendencies, she was tasked (as her assignment for the next session) to find a reason for living. The rationale was to keep her mind focused on positive thoughts instead of negative ones.

Comments: There was not much that could be pointed out in terms of change as a result of positive cognitive reframing or identifying, challenging and changing negative automatic thoughts and assumptions, seeing that the participant could not incorporate these strategies into her perception. She merely reacted by nodding her head and saying: “yes”. The reason why the client battled with these therapeutic skills was that she was not yet used to this way of thinking.

Session 2

Her homework assignment, namely to find a reason for living, was explored in this session and she indicated that she wants to be a role model to her children and others. She also mentioned that she wants to accomplish certain things in future such as working for her children and see them growing up and building a home for them. She further stated that she wants her life to be normal so that she should not fear living with this disease. It could be noticed that the participant was hopeful about getting help and was also starting to think in a future-orientated way about living with the virus – the change process could be as a result of the homework assignment she successfully completed.

In this session, the participant’s guilt feelings, which included anger that was directed inwardly in the form of self-destructiveness or suicidal behaviour, were discussed. For instance, the researcher used positive cognitive reframing to address these feelings. He said that it was also good for her to have goals that she wanted to accomplish, rather than entertaining possible guilt feelings and suicidal thoughts. She was further made aware that she had to think of HIV in a positive way because she cannot change her status. Positive cognitive reframing was aimed at assisting her to look for other ways of thinking about her diagnosis, especially when negative thoughts about suicide arose. Her response was: “I am able to learn a lot of things from you since I started attending and I realise that I can still go on in life”. Positive cognitive reframing was taught in this way: “as long as you follow all the necessary rules for HIV/AIDS treatment and adopt a positive frame of mind, you can live longer”. Her answer was: “I used to have a lot of anger, but I am better now and I no longer cry because I have a way of handling this now”.

Her negative automatic thoughts about dying soon were questioned when the researcher mentioned: “did you think that you were going to die soon before contracting this virus?” She replied by shaking her head, implying no. Her negative thoughts were challenged further when the researcher said: “now that you live with the virus, how come that you should think that you are dying soon? Do you perhaps know when are you going to die?” (Socratic questioning and reality testing.) Her response was: “I am now thinking that I may live longer than a healthy person provided I accept myself”. Her homework assignment was to monitor all the negative thoughts, especially suicide and blaming herself that crossed her mind. In addition, she was tasked to think of what to do when faced with negative automatic thoughts.

Comments: She showed better progress with regard to grasping positive cognitive reframing technique, as she stated that she was able to handle the tough things she came across. She remarked: “I would feel bad and emotionally down on other days, but you are equipping me to deal with it and to accept”. Her homework assignment proved to be effective because she was starting to change her negative thinking to positive thinking (that is, from feeling suicidal to regarding herself as a role model). She managed to identify her underlying thought patterns through the method of Socratic questioning and reality testing when she was questioned about her automatic thoughts of dying soon because she was hopeful about living longer.

Session 3

In this session the client’s homework assignment was discussed. She pointed out: “...I often experience anger directed inwardly. I ask myself why I am still living, because I am going to die soon. I also used to think, why I am not killing myself, especially if I have a problem. When I think that way now, I am able to talk to other people and I deal with it. I also think the fact that I am unemployed exacerbates this situation. However, it is better now because I have people around me at this stage”.

Her negative automatic thoughts were challenged: “do you realise how you perceive this disease?” She responded by shaking her head, implying no. The researcher showed her through positive cognitive reframing that unemployment has nothing to do with HIV/AIDS, since it is a common thing in our country: “so it does not mean that you should perceive yourself as being unemployed because of the virus. You know that you are living with the virus and that you are not able to change it, but you can change the way you perceive yourself”.

The participant’s feelings of powerlessness, including her loss of confidence and self-worth, were explored in this session through positive cognitive reframing, when the researcher stated that these negative thoughts about death are some of the things that can have a negative impact on her self-confidence and self-worth. The emphasis was placed on the way she looked at her HIV which caused

her to feel bad about herself because she had internalised it. Of significance was to perceive it in a positive, instead of a negative way. Her answer was: “that is what makes me angry in most cases and I think – why do I have to live? I do not think of other issues at that time but of death alone”.

When she was asked to explain about things that were bothering her, she indicated that people who annoyed her were those who were not careful about how they talked, would just be rude to her and reminded her that she was sick. She was also shown alternative ways of managing her diagnosis, especially with regard to dealing with the stigma she was faced with: “you cannot change other people’s perception of people living with the disease. People may say anything that they want to say to you and you have to deal with that by adopting a positive way of looking at your situation”. Decatastrophising technique was taught with an aim of equipping her to re-assess and modify her negative thoughts. For instance: “you need to be prepared for the worst, since people are not as sensitive as you would want to see them and when you encounter such behaviour, it should possibly not bother you much”.

When asked about other issues she wanted to raise for the day, she indicated that her elder child does not listen when she talks to him and fights elderly people and she becomes hurt because of that, and then thinks of dying. She was given information that she should consult psychologists for assistance and she agreed by nodding her head while crying. Some coping strategies were taught regarding her 12-year-old son, who was troubling her. For example: “this could be seen as one of the challenges that you are faced with at this stage. It does not necessarily mean that it is because of your HIV status that you are experiencing difficulties with your son, as this could happen to any other person”. Problem-solving skills were taught that it would be important to deal and look at his behaviour in this way that he is possibly experiencing behavioural problems and should be referred for the help that he requires. Her assignment for the next session was to reflect on how to enhance her level of confidence.

Comments: She appeared to be hopeful due to the information on the coping strategies and problem-solving skills that was taught concerning her troublesome son. She mentioned: “I am feeling better and relieved now that I know where to go for help ...” In this instance, she was referring to the fact that the researcher recommended that her son be referred for psychological assistance. Her homework assignment about monitoring all the negative thoughts that crossed her mind seemed to have worked, because she was able to successfully identify such thoughts that had been discussed in this session. Positive cognitive reframing seemed to have been effective as the woman regarded herself to be similar to any other person. The researcher felt that the cognitive reframing technique started the change process, as it could be noted that there was a positive change in terms of how she perceived her diagnosis.

Identifying, challenging and changing negative automatic thoughts and assumptions worked well, possibly because she could identify her source of suicidal ideations. Decatastrophising techniques seemed not to be effective, as she only reacted by merely nodding her head. Another factor that probably contributed to her lack of progress in therapy was that she mentioned burying family members due to HIV almost monthly. This obviously had a negative effect on her coping.

Session 4

Her homework assignment, namely to reflect on how to enhance her level of confidence, was dealt with and she stated that for her confidence to be boosted, she has to trust, believe and accept herself the way she is so that it would be easier for others to trust her. She also indicated that she wants people to see her as a role model, so that they can be aware that one can live longer even if living with the disease. Some coping strategies were taught that regarding herself to be a role model and helping others to cope will in turn help her to cope better. Her answer was: “I think that what I am doing is good, because if I talk to others I may be saving the lives of many parents who would die and leave their children as orphans. That boosts my confidence a lot, because I think I am needed by my community”.

The implications of the woman’s behaviour such as her self-pity, self-isolation and suicide, were dealt with in this meeting when she was trained to consider alternative interpretations for her diagnosis through positive cognitive reframing. For example: “you do not have to pity, isolate and neglect yourself, because you have an important role to play in the community. Being HIV positive does not mean that one withdraws from the society. It means you see yourself playing a significant role for others and that it is not the end of the world and other people have a lot to learn from you since you are their role model”. Her response was: “I also need to see myself working somewhere and living a normal life like others in order to show people that you can still work despite living with the virus. You should not be like a person who always relies on other people, telling yourself that you are no longer capable of doing anything because of the sickness”. Her homework assignment was to reflect on how self-pity, neglect, isolation and thinking about death would enable her cope.

Comments: When asked about her progress with the coping strategies that she was taught, she replied: “I am all right for now and I am able to cope with daily problems that I am experiencing. With regard to the recent deaths, I have to tell myself that I am aware that my family is struggling to cope and we are not the same, and I am in the process of dealing with it. That is why I want my family to regard me as their role model”. Her homework assignment proved to be effective as she had started to see herself as a role model. The technique of cognitive reframing also assisted her to consider alternative and more positive interpretations for her diagnosis because she wanted to see herself living a

normal life like others. It is during this session that the researcher noted that the participant was grasping the strategies, as she responded positively showing some understanding of them. It can be concluded that when she started to think differently about her diagnosis she then perceived herself to be similar to others.

Session 5

Because of the internalised stigma that the participant was facing, the session focused on her experience of the reaction of others, as well as on her previously assigned tasks. She reported to have not done her homework assignment as she lost two of her cousins and it was hard for her. She further reacted: “I was hurt a lot but now I am better, because I have to be strong for my family. They have to see me as the role model and that a person can live with the disease and accept it”. Despite several deaths in the family due to HIV/AIDS, it could be seen – in the manner she regarded her status – that the participant was trying to be positive.

A positive cognitive reframing was taught to enhance her coping skills: “you are probably going to live longer because of the positive way you regard yourself. These deaths occurring in your family must have been hard for you and could be seen as challenges”. She seemed to be agreeing with this suggestion by nodding her head. Upon being reminded of her assignment, she indicated: “I do feel that I pity myself, especially when I think about death, but I am now better since I engage in conversation with others”. She was trained further in alternative ways of thinking about death. For example: “we are all going to die at some stage. What is important is: how do we perceive death? So, do all you can at this stage to live and think in a different way? Thus you may live longer”. She reacted: “the other thing is that I do not feel guilty, because if I believe in God who has given me a second chance in life and I believe I have to live well. Feeling guilty and isolating myself may not help me to cope, that is why I do not entertain such thoughts and I forget about them”.

Anti-discriminatory laws were taught to equip her with the necessary knowledge and ways of dealing with discrimination. For example, she was taught that in case it happens that there are people who discriminate against her by threatening to kill her because of the disease, she can open a case against such people at the police station – as it is her right to be protected by law as an individual. Assertiveness and social skills training was taught, given the social problems she experienced and people’s negative comments when she was diagnosed HIV positive. For instance: “it would also help you to assert yourself when talking and interacting with others. Talk to the people in a more polite way without any form of quarrelling or argument. By being assertive you are avoiding unnecessary fights, stress and arguments with people”.

Decatastrophising was suggested to assist her in anticipating the worst as she was already disclosing her status to people. For example: “if you talk to people, you need to be prepared that some may listen to you and some may not. If they

do not listen to you, it should not hurt you, because you were waiting for such negative responses”. Given her lack of assertiveness, she was instructed to practise assertiveness in her interaction with others.

Comments: She appeared to be progressing well as a result of positive cognitive reframing suggested to her, because she said: “... I am now feeling better, I am able to accept myself the way I am, because all the people on earth are any way going to die. You may not die because of diseases but there are many ways in which you can die”. It could be seen that positive cognitive reframing changed her perception of this disease. Her homework assignment for the last session worked out well although she had to be reminded of it, because she had several deaths in the family. She stated that feeling guilty and isolating herself may not help her to cope. It should be noted here that the participant had an improved grasp of these cognitive behavioural strategies and was at ease with them. The difference was brought about by the fact that she practised most of her assigned tasks, which helped to effect a positive change in her thinking.

Assertiveness training did not work because she only reacted by saying: “yes” and the reason for the technique not being effective could be that it was still new to her. Decatastrophising and the education she received about the anti-discriminatory laws also proved not to be effective as she only reacted by saying: “yes”. The reason could perhaps be because she knew the technique or did not need it since she already disclosed and were already making changes in her perception about HIV.

Session 6

Her uncertainties about the future and the assignment were discussed in this session. She responded that before talking to people, she has to carefully think about what she has to say and has to respect herself first before she could be respected and understood by others. She mentioned that she does that so that if she talks to people about HIV/AIDS they should be able to understand her.

Assertiveness training was recapped in this session because she had not developed the technique in the previous meeting: “if you talk to people in a respectful way it would assist you to manage the stress you could come across”. The aim of asserting herself in her environment was that she had certain goals, namely to help others to change their perception of internalised stigma and discrimination. Her answer was: “I also have to talk well to those who are hurting me and causing me pain. I should not just get angry, because I hurt myself by being cross and not solving the problem”.

Decatastrophising was taught again, as she had been battling to grasp this technique in past sessions. For example, she was shown that being prepared for anything that might come from people by anticipating it would help. Her response was on a different topic instead of decatastrophising. It was clear that she was

still battling to grasp this technique, as she commented more on being seen as a role model rather than on the technique that was taught. She was tasked to consider her plans for the next five to ten years. The aim of this homework was to further facilitate change during therapy.

Comments: She reported to be progressing well as a result of the homework assignment she was given, because she was able to assert herself in her environment. She wanted to play a pivotal role in her family, as she pointed out that she buried a family member almost monthly due to HIV/AIDS, and she was encouraging them about testing in order to prevent the spread of the virus. Decatastrophising techniques appeared not to be effective towards preparing her for the worst that could happen as she was addressing others about the disease. The death of family members due to HIV/AIDS was an initial reason for her not reacting well to therapy, but now it became a motivating factor for her to live, as it gave meaning to her life.

Session 7

Coping strategies as well as the tasks assigned in the previous session were dealt with in this penultimate session. When the participant was asked to talk about her homework, she stated: “my plan for the coming five years is that I would like to see myself working and being a good mother to my children and have a house for them. I am thinking that death could come to any person at any time and I do not have to entertain the idea of dying soon”. She further stated that she would like to see herself being married and enjoying marriage life like any other person and was asking God not to die before getting married and accomplishing all her dreams. She furthermore indicated that she was asking God to be with her and help her to educate other people about this disease. Thus, they can see that one can live longer with it.

Decatastrophising techniques were again taught to prepare her for the worst thing that could happen – that is, being discriminated against, as she was addressing others about the disease. The researcher said that to make room for any other form of disappointment would help her, so that if the worst happens to her, she would be ready to handle it. Her answer was: “I need to accept that one has to make room for disappointments as long as you live on earth”.

Coping strategies that were taught focused on the researcher mentioning that it would also benefit her to join support groups in order to share with others the difficulties she was faced with. That would help her to realise that she was not the only one who has problems of dealing with stigma and discrimination, as there are other people who are encountering similar problems. She was further encouraged to use the time she was left with to effectively accomplish all her goals. She appeared to understand the suggested ideas. For the last session, the participant was tasked to imagine future difficulties and how to deal with them.

Comments: The client appeared to be continuing well as a result of therapy and the way she perceived herself, especially as a result of the homework assignments she received, which proved to be effective in facilitating change, as she wanted to accomplish all her dreams before dying. She seemed to be positive about her future and understanding the coping strategies that were taught when she said that her aim was to live longer with this disease so that she should be a role model to her children and people in the street. The decatastrophising techniques also worked well as she was accepting that one have to make room for disappointments.

Session 8

Coping strategies were repeated in this last session to make the participant aware that she may still continue to cope and live longer with the disease. Her homework assignment was explored and she mentioned: “what if my friends and some of family members are no longer friendly towards me? The other things that I am imagining concern my children about what would become of them if I die, what type of life would they live and with whom?” When asked what she would do when coming across such difficulties, she answered that she needs to talk to other people who are reliable and that she can share her difficulties, so that she should know that there are people to support her if she were to die.

She was further taught coping strategies: “it would also assist you to talk to your parents or siblings and arrange what would happen to your children should you die. By doing that, you would be focusing on possible solutions for the difficulties you are faced with”. Additional coping strategies were taught that she needs to continue living her normal life and remember that she has a role to play in de-stigmatising this disease. She stated: “the other thing that I would often come across would be that people would make bad remarks because of lack of knowledge. That would hurt me and make me feel small as if I am going to die at that time. I now understand that I have to prepare myself and be ready for their comments, so that if they are offensive, I would then manage to cope with their discrimination”.

Decatastrophising was taught to help her further deal with stigma she might experience: “preparing yourself for the worst helps you to gear yourself for people’s bad comments by expecting anything from them. If people continue to discriminate against you, you should bear in mind that there are anti-discriminatory laws to protect you”. Her response was: “I have started to tell myself since I saw you for therapy that I am going to live longer, because I still have future plans for me and my children, despite people’s remarks”.

Positive cognitive reframing was further taught: “even if you happen to fail in life, you still have to regard that failure in a positive way and be aware that you may not succeed and excel in all areas of your life. Of significance is how you perceive that failure”. She reacted: “the other thing that I have come to realise is

that I need to thank God for giving me a second chance; other people have recently started knowing about their status, and I have been knowing about my status for some time and I am still living while others are dead. I still need to live longer and be an example to others”.

Comments: Decatastrophising technique worked well, as seen in the previously assigned homework that she could imagine future difficulties and was able to say how she would deal with them – as she referred to talking to family members who would take care of her children if she died. She showed good progress as a result of the coping strategies that were taught and it seemed that these techniques worked well, as she said: “I came to realise since I started to see you for therapy that one is not a failure in life, since you still have to strive to reach your goals as a person. Even if you do not have other parts of your body, you still can go on with life if you want to do so, and you would not be regarded as a failure”. It could be noted that the coping strategies brought the change process regarding her attaining her goal.

Positive cognitive reframing proved to be effective in enabling her to think positively, as she pointed out: “I also used to think a lot about why I am not dying soon, because I am now useless due to the disease I live with. However, I have come to realise through therapy that my life, my children and the family are important”.

Overall discussion of participant 6

All in all it can be seen that the strategies that appeared to be effective were the identifying, challenging and changing negative automatic thoughts and assumptions that started the change process and altered negative thinking, as she was feeling suicidal and was now positive in her thinking. She showed to be positive about her future as a result of the problem-solving skills that made her to realise that her son’s problems are not due to her disease but any other parent could encounter such problems. Positive cognitive reframing changed her negative way of thinking about death because she said: “all the people on earth are going to die. You may not die because of diseases but there are many ways in which you can die”.

Teaching of coping strategies proved to be effective as she came to realise that feeling guilty and isolating herself may not help her to cope but talking to others about the disease will enable her to cope. It could be seen that this strategy worked well in changing her self-isolation behaviour. The technique of giving a homework assignment worked well, as she successfully completed the tasks that facilitated change in therapy such as monitoring all the negative thoughts that crossed her mind. Decatastrophising techniques also worked well in modifying her negative automatic thoughts and her feelings of powerlessness about her diagnosis, and it further assisted her to anticipate the worst in dealing with stigma. Assertiveness training proved to be effective in assisting her to assert

herself in her environment, especially in dealing with her family. The reason why most CBT techniques proved to be effective is perhaps that only a few of these strategies were presented at a time, which possibly assisted the participant to react to what was suggested.

It can be seen that the intervention model was a success in this case, because it enabled her to deal with stigma she was experiencing. Therapy addressed her feelings of suicide and powerlessness, self-isolation, fear of death, anger, negative perceptions of her future and her diagnosis – and changed them to thinking positively about herself. The positive change that was observed was confirmed by the post-therapy psychometric evaluation. In this evaluation the participant experienced less scores on depression (39 before which is severe depression to 9 afterwards which is considered in the normal range), less internalised stigma (43 before; 22 after), more self-esteem (6 before; 0 after), and positive ways of coping (45 before; 48 after).

Participant 7

Session 1

1. Context

This interview was conducted with a 27-year-old female participant who was seen at Witbank Hospital for the purpose of the research. As in most of the other cases, the aim was to empower her to deal with stigma and discrimination related to her HIV-positive diagnosis. She reported to be single and had no children. She mentioned that she came from a family of eight children from her father's side, with each of the eight children coming from different mothers. She was the firstborn child on her mother's side and she had only one brother.

She indicated to have been experiencing anger following her diagnosis because she was not prepared to disclose her status to the family. It was however disclosed by a friend who came to the clinic with her to find out about the results of her test. When they informed her of the results of her HIV test, she was with this friend in the consulting room and that is how the friend found out. She felt rejected by the family who now knew about her status, especially her father, who told her to go and stay in an empty stand. He accused her of liking men and that that was why she got infected. He also told her she should see for herself how to cope with the virus. From what she pointed out, it could be clearly seen by the researcher that she experienced enacted stigma. She was crying a lot throughout the session as she spoke about discrimination, and she said: "my father chased me out of the home and I then went to stay alone. I was deeply wounded by that". After being chased out of the home by her father, she went to stay with an aunt. There she was still discriminated against, because she was given her own plate and spoons to use because of her HIV status.

She reported to be staying in an informal settlement with a cousin at the time of the research. She stated that the place where she lived was not a good one for a person living with HIV to stay in. She said: “you would be shocked if you could see it ...” She stated that her mother was not living with her but resided in another province. She never bothered to call her daughter when she heard about her status. Her boyfriend was indicated to be living in KwaZulu-Natal and he was not aware of her status.

She stated that she thought about death most of the time, because she said: “even if I wish to do something I always think that I am HIV positive and I am going to die at any time”. She perceived her future as dark following her diagnosis and her HIV diagnosis had affected her because she pointed out: “this disease has drastically changed my life, as I am no longer taking care of myself like I used to”. She suffered from a low self-esteem and tended to neglect herself following her diagnosis.

She felt guilty about living with the virus, and did not sleep well. She experienced a lack of support, especially financial support from her family. This contributed to her suicidal thoughts. When she thought of taking her medication, it was not possible, because she could not do that on an empty stomach. On the other hand, her father was reported to be a capable business man who could provide her with food but he did not. He helped other people, but he would not help her. She was experiencing stigma and discrimination from others as well, because she indicated that: “people perceive you as something like an animal if you live with this disease ... that is hurting”. She tended to withdraw and isolate herself from others. She stated that her HIV status had caused her not to have fun any longer and she coped by playing games on the cell phone. She further hoped that maybe miracles would happen to her one day and that God might cure her.

2. Definition of the relationship with the counsellor/researcher

She entered the relationship in a one down position by following the therapist’s lead. She maintained eye contact during therapy and her tone of voice was soft.

3. Distance (Punctuating from the participant’s point of view)

3.1 Acceptance of reflections

An appropriate distance was maintained by the participant throughout the therapy session and she did that by accepting the researcher’s reflections of her feelings.

3.2 How did she express herself?

The client cried throughout the entire first session and she spoke about her HIV status in a transparent and congruent manner. She did that by giving details

about how her family discriminated against her. She presented her diagnosis in a helpless way and talked about the way she was hurt. She was mainly blaming others and herself for living with HIV/AIDS.

3.3 Manoeuvres and behavioural patterns

A pattern of closeness was maintained throughout the therapy session. That was noticed when she accepted reflections of feelings and was manoeuvring for sympathy, support and understanding. She continued to cry and spoke about her status in a defeated and helpless way. This could be regarded as learned helplessness.

4. The client's support system

Her support system consisted of parents and siblings who were discriminating against her, including her immediate relatives. It was evident that she lacked moral and financial support. Her aunt was also not supportive, as she was given her own plate and spoons to use because of her HIV status. Not much could be said about the cousin that she stayed with, perhaps because she did not know about her HIV status.

5. Hypothesis

Because of the stigma and discrimination she was experiencing mainly from the primary family system and others, she felt depressed and suicidal, and experienced anger directed towards herself. She tended to isolate herself from others and to neglect herself. Her interactional style had distancing effects that caused her to have a negative attitude towards herself and to experience suicidal thoughts and have a low self-esteem.

6. Symptoms

Her negative automatic thoughts such as suicidal ideations and depression were the result of stigma and discrimination that came from family and others.

7. Goals of therapy

The purpose of CBT was to empower her to handle the discrimination she encountered and to deal with her low self-esteem and depression.

8. Type(s) of intervention used and the reaction of the client

The participant appeared to be worried about death following her diagnosis. These negative automatic thoughts that caused her to be preoccupied with dying at any time were addressed: "are you perhaps aware of the fact that we are all going to die at some stage?" The researcher further indicated: "how was it before

you were diagnosed with HIV? Were you living and hopeful that you were going to proceed with your life?” (Socratic questioning and reality testing.) Again her answer was: “yes”. Her negative thinking was further reframed in order to help her to consider alternative ways of viewing death: “it would be important to appraise or look at your situation in a different way, as you are on treatment that will help to prolong your life. Death occurs to any other person as a result of any other thing”. Her homework assignment was to find a reason for living, since she seemed to be preoccupied with suicidal tendencies.

Comments: She seemed to be slightly relieved emotionally and that was seen on her face at the end of the first therapy session. This could be because she was hopeful about being equipped to deal with the stigma, she said: “I was initially shocked and struggled to fall asleep, but I told myself that I cannot make my situation disappear. Whatever I was told, I had to accept”. She appeared to be battling to fit the positive cognitive reframing, and Socratic questioning and reality testing techniques into her perception as it was perhaps unfamiliar to her, because she only responded by saying: “yes” during therapy.

Session 2

The participant’s feelings of powerlessness following her diagnosis were dealt with in this session, as well as her assigned task. This is how she commented on her homework: “I would say that I still have things that I wish to do in my life so that I can take care of the child whose mother died. The one I drew on that picture (*referring to the life map*), as I used to call her mother. She is deceased now and I want to give her child the love that her mother used to give me. I also want to help others who have been helpful to me”. It could be seen that she was hopeful about life and was starting to perceive herself in a positive way.

She complained of lack of support from her family as she stated that she requested them to give her some maize meal and her father told her that she must go and look for work as she left school earlier. Thus, she sees her parents as just useless to her. The researcher assisted her to manage her diagnosis through coping strategies: “you seem to be feeling powerless at this stage. Think of a probable plan such as using the support of others, other than your family. That can perhaps make you feel better”. She was hurt by her father who does not lack money and yet was not able to help her but was able to help others who are relatives and strangers.

Her automatic thoughts of blaming herself for contracting the virus were questioned (Socratic questioning and reality testing) with the aim of challenging the validity of the cognition. For example: “what wrongs did you do to contract the virus and you do not have to blame yourself, because that may not help you much. Were you blaming yourself before you were diagnosed?” She reacted: “no, and I have done nothing wrong”. Her negative automatic thoughts were further challenged: “how come that you should now blame yourself and for

what?” He further mentioned: “do you see that this is what is making you to feel powerless and blame yourself?” She reacted by answering: “yes”.

Cognitive positive reframing was taught to enable her to deal with her lowered self-esteem. For instance: “you do not have control over how people perceive this disease, but you have control over how you see yourself. It is not your fault that you live with this disease. So, why do you then blame yourself and do not live the type of life you used to live?” The aim of this strategy was to empower her to think of herself in a positive way rather than thinking of her family, who seemed to be discriminating against her. Her answer was: “I can hear what you are saying. It is only that the people who used to help me a lot are no longer here because they are far and I do not have contact with them”.

When asked about where she mainly receives support, she stated: “I do not know, as I am just living”. Her negative automatic thoughts about just living were challenged: “you are not just living, as you earlier on pointed out to me that you want to help and love others, seeing that you were once assisted by those people”. She seemed to be agreeing with these suggestions. She was told to reflect on how to keep her confidence level higher, since it was lowered by her family’s discrimination against her.

Comments: The woman appeared to be doing well on the homework assignment she was given, as it assisted her to think in a positive way and to find a reason for living. In this instance, the homework assignment she received started the change process. Socratic questioning and reality testing about blaming herself also worked well as she started to realise that there was nothing wrong that she did to contract the virus. Positive cognitive reframing strategies that were presented appeared not to be effective and seemed difficult for her to understand, because she only reacted by merely saying: “yes”. Teaching coping strategies also proved not to be effective, as she reacted with anger when showed how to deal with her family that was not supportive. She said: “one day he might come to request help from me, maybe because he could be bankrupt, and I would be seen as a bad person because I would not help”. Identifying, challenging and changing negative automatic thoughts and assumptions did not either work well as she responded by saying: “yes”.

Session 3

The previously assigned task was discussed in this session. Her reaction was that she told herself that she can do anything in life even if she was HIV positive. She further indicated that she was no longer bothered much about this disease because she regarded herself to be similar to other people. She mentioned that she still had goals to achieve such as working, having a house and family, and also a car. These goals were stated to be assisting in preventing her from feeling bad about herself.

Her guilt feelings, which included anger that was directed inwardly in the form of suicidal thoughts, were questioned (Socratic questioning and reality testing): “did you have guilt feeling before you were diagnosed?” to which she answered: “no”. The researcher further cross questioned her negative automatic thoughts by saying: “you did not, as you mention it. You possibly saw yourself dying at a later stage. You wished to be a successful business woman, as you stated. So what prevents you from being the person you wished to be, now that you live with the virus?” She reacted: “nothing, except that my body easily gets tired when I do hairstyles”.

Graded task assignment was taught to assist her to set goals that can realistically be achieved: “try to arrange with the people whose hair you braid that you will do that and stop as soon as you feel tired. You can for instance do the 6 hours’ work with frequent brakes to allow you to rest”. She seemed to understand this line of thought. Some coping strategies were taught to help her further deal with stigma. For example: “try to accept that there are things you can change and others you cannot change, like your lack of energy and you have to handle your customers according to the level of energy you have”. She reacted: “some people might hurry you especially if they have paid up for their braids (*laughing*)”. The researcher stated that she can prepare some of her customers that it will possibly take longer than anticipated.

When asked if there were other issues she wanted to talk about she said that her father sent her brother on Sunday to bring her food and she thought that he was feeling regretful. Positive cognitive reframing was taught: “it might help if you do not rely on him. Therefore, if he brings food to you, it could be seen as an extra benefit to you, since you do not expect anything from him. That is how you should see it, as you cannot change the way he talks to you, but you can change the way you see him”. She reacted by being silent.

A decatastrophising strategy was taught to help in re-evaluating and modifying negative thoughts that disturbed her and prevented her from coping. For example: “it could help you if you do not expect much from your parents, since they are disappointing you. You should know that they are still alive, yet not available when you need them. Learn to prepare yourself for the worst with regard to your father, so that if he happens to assist you, that should be seen as an extra benefit, since you were not expecting it”. She responded: “I can hear you there – it is only that I have thoughts that cross my mind when I think of this ... I feel rejected by my family”.

Her negative self-evaluation was questioned through Socratic questioning and reality testing: “could I find out if you still feel rejected when your father brings you food on a particular day?” She responded: “no”. He further confronted the negative thoughts by pointing out: “so how come that you feel rejected on a day you do not have food?” Her answer was: “yes”. Her homework assignment was

to monitor the negative thoughts and beliefs that disturb her behaviour and to learn to cope with them.

Comments: She showed good progress in thinking positively as a result of the homework assignments that were effective and that brought change in her thought process, as she regarded herself to be similar to other people. Other strategies, namely decatastrophising, graded task assignments, teaching coping strategies, positive cognitive reframing, as well as Socratic questioning and reality testing proved not to have immediate effect though she engaged with the thoughts. Her reactions were often to become silent and just saying “yes”; maybe because she was not familiar with these techniques and they did not fit into her frame of mind. It can be noted also that many strategies were presented at once, which possibly made it difficult for her to grasp these skills, as she possibly needed time to think about the statements that were suggested to her.

Session 4

Due to the fact that the participant felt rejected by her family and tended to neglect herself, the effect that such treatment had on her behaviour such as self-pity and self-isolation, was dealt with. Her homework assignment was discussed in this session and she said: “I am now able to deal with the negative thoughts that cross my mind since I started to see you. I now regard myself like other people and I become better equipped to handle my situation, and I can still see myself achieving most of my goals”. When asked further about the negative thoughts that cross her mind, she indicated that she at times feel lonely and negative thoughts then occur. She then tries to deal with her loneliness because she keeps company with her neighbours to talk to them.

Positive cognitive reframing was taught so that if negative thoughts cross her mind, she should still regard herself in a positive way like any other person and live a positive lifestyle. She was further taught to help her regard HIV as similar to other diseases. For example: “thinking of your diagnosis in a positive way will enable you to further gain self confidence and to continue living”. Her response was: “I am now able to handle other people who talk bad about others who have AIDS. I advise such people that they themselves might be living with it. I am not specific though that I have contracted the virus. I try to show them that AIDS is not a monster”.

Coping strategies were taught to help her to adhere to a treatment regimen, eat a balanced diet, live a positive lifestyle and use a condom when engaging in sexual activity. That will help to prolong her life. She was shown that she was being useful to others, as she was educating them about combating the spread of this disease. In return that would help her to cope better. Decatastrophising was taught to further prepare her to deal with stigma: “please bear in mind that not all the people you will come across will speak positively about this disease and that

you cannot change them despite having talked to them. It is therefore not your fault and anticipates such behaviour from others”. She reacted: “yes”.

She was still finding it difficult to disclose her status to her cousin with whom she was staying. She was taught alternative ways of managing her diagnosis and showed the importance of disclosing her status to her cousin. For instance, she was told that her cousin would possibly offer her the necessary support, especially when sick. She reacted: “I am grateful for such ideas, because I did not have a way of dealing with her”. She was tasked to reflect on how self-pity, self-isolation, self-neglect and thinking about suicide would help her to cope. The rationale was to make her realise that these behaviours were not adding value to her situation.

Comments: Her homework assignment seemed to be effective in helping her to identify negative automatic thoughts and to manage them. She was also assisted to disclose her status to her cousin who could be a possible source of support to her. This assistance seemed to be effective since she obviously gained more insight into handling her cousin. Positive cognitive reframing was also effective in enabling her to think positively about her own stigmatising thoughts about HIV as she seemed to be helped to think in a positive way. It could be noticed that she was now becoming familiar with the above-mentioned CBT techniques. Decatastrophising and coping strategies proved not to be effective and perhaps difficult for her to grasp, as she only reacted by saying: “yes”.

Session 5

Due to the stigma and discrimination she was faced with, the session focused on dealing with the experience of the reaction of others. Her homework assignment about reflecting on how self-pity, self-isolation, self-neglect and thinking about suicide would help her to cope was explored, and she stated that that was not going to help her at all. She also mentioned that she keeps company with others because if she were alone she forever thinks, cries and get stressed up. She told herself that she looked like other people since she was not different from them.

A positive cognitive reframing was taught to assist her to further think in a positive way by mentioning that it is about changing her attitude and regarding herself like any other person even if she lived with this disease. Her response was: “yes, the way you think of yourself”. Anti-discriminatory laws and decatastrophising strategies were taught to prepare her for the worst reactions that she might encounter as she would be disclosing her status to others. For example she was taught that there are anti-discriminatory laws to protect her if she were discriminated against because of the disease. A case could be opened with the police if she were being discriminated against.

Assertiveness and social skills training were taught through role-play to equip her to assert herself in her environment as she would be talking to others about her

status. For example: “however, you still need to respect and be polite to others, even if you have the anti-discriminatory laws on your side. You need to change the way you talk to others if you were possibly rude to them. Say to them, ‘I live with the disease and I cannot change that.’ By being assertive means that you believe in yourself and you say something in an assertive way without arguing with others”.

Upon being asked about other things she wanted to raise for the day, she indicated that she disclosed her status to her friend last week. She stated that her friend discussed her HIV status with her boyfriend, who told her that she should not be her friend because she would teach her to like men. She was hurt by such news. Her negative automatic thoughts about perceiving herself as a person who likes men were challenged and she was shown that being HIV positive does not mean you like men. An example of a newborn baby girl who has been tested and found to have the disease was made with an aim of showing her that it does not mean that she likes men. She reacted by laughing.

Decatastrophising strategy was repeated to further make her aware that if she told one person about her status that person is more likely to tell others, so she needs to be prepared for the worst now that she would be talking to others regularly. Her response was: “when you talk you become well and free emotionally and when you avoid talking, you develop fear and worry. You can even get help from others by talking to them. If you talk about it, you get used living with the virus and you know that you cannot change that”. The aim of her homework, which involved the practise of cognitive and behaviour techniques in between the sessions, was to practise perceiving her HIV status in a positive way and to practise assertiveness in real-life situations.

Comments: Her homework assignments proved to be effective in affecting her perception of the disease positively by keeping others company as she regarded herself not different from them. She reported to be continuing well as a result of the positive cognitive reframing that was successful, as she said that she was aware that she lives with the virus and knew that she cannot change that. A modification of negative automatic thoughts through the method of decatastrophising also proved to be effective in preparing to anticipate the worst when coming to disclosure of status. It was evident that she was slowly coming to terms with her diagnosis and seemed to be finding it easy to understand how to use these skills. However, the identifying, challenging and changing her negative automatic thoughts and assumptions, as well as assertiveness and social skills training that was taught through role-play did not work well, perhaps as she was unfamiliar with these techniques or did not see how she could apply them, because she responded by merely nodding her head and saying: “yes”.

Session 6

The client's uncertainties about the future were dealt with in this session. Her homework assignments were discussed. In reaction she stated: "I do talk well to others about my disease and inform them of how to cope with it. I tell them that I live with HIV and they ask me about it and I respond to them well by encouraging them to use a condom when engaging in a sexual activity since the virus is in the blood. They see me living and are encouraged to undergo testing". It could be seen that she had started to be perceived as a role model by others to whom she had disclosed her status.

Assertiveness and social skills training were further taught to equip her to assert herself in her interaction with others: "the manner in which you would be talking to the people in your attempt to assist them deal with stigma and discrimination is important, because if you are going to be rude to them it would not help them. If you are able to assert yourself in your environment and to politely talk to them, it would help people to receive assistance from you".

When asked about issues she wanted to raise for therapy, she indicated that her neighbours knew that she lives with the virus and they did not discriminate against her, although her family and relatives still discriminated against her. She pointed out that she has asked one of her neighbours to look after her since she was on treatment and she has agreed to do that. A few coping strategies were taught to show her the significance of using the social support offered by others other than her family that seemed not to be available for her. Her assignment for the next session was to consider her future plans for the next five to ten years.

Comments: Her previous homework assignment about practising to assert herself in her interactions with others proved to be effective as seen above that she could assert herself in dealing with others. Teaching coping strategies proved to be effective in changing her behaviour to deal with discrimination, as she said: "I tell them that the important thing is to accept, because if you do not do so, you end up isolating yourself and thinking continuously about death. I tell myself that death has been created by God and why should one worry more about it now that you know that you are HIV positive". It is at this stage of therapy that the researcher felt that the participant had grasped the CBT techniques, because she was no longer ashamed of herself and was talking to others about the virus with the aim of helping to combat the spread of HIV.

Session 7

The focus of this session was on coping strategies, to further consolidate what she has gained in previous sessions. The participant's assigned task was discussed and she replied that she plans to start her own business by selling fast food. Her biggest dream was to buy her own car and house, and to adopt her brother and help her other brothers and sisters to realise their dreams. She

further mentioned that she planned to start a project where she can help orphans, sick people, elderly ones and those who have problems. She finally pointed out that she would also be pleased to have a garden where we can plant vegetables. From these statements, it can be concluded that the client was seeing her future in a brighter way and that her homework assignments were facilitating the change process.

She was asked about the steps she had taken to achieve her plans and she answered: “at the moment I am trying to arrange to meet successful people to find out from them how they have managed to be successful”. Coping strategies were taught in order to assist her to achieve her plans and was advised that she needs to have financial backup when considering starting a business and that she perhaps need to start small in order to grow big.

She further added that her father was regretting and was slowly starting to accept her, because he phoned her requesting her to help at his shop. She would like to help him but she had a problem with the people who work for him because they do not like her. On the other hand, she stated that if she refused to help him, he would perhaps tell her that she should not come to him if she needs assistance.

Problem-solving skills were taught that it could be wiser if she discussed her difficulties with her father because that might help her to decide about what to do since she was caught in between. She responded: “my father seems to be regretting of late and is taking me seriously, because he does not want to see other people at the supermarket and he wants me to be in charge. My aunt discussed with my father all my complaints about the lady who is in charge of the supermarket. I think of many things as a result of this and I think this is going to result in stress”.

The researcher further pointed out the advantages and disadvantages of dealing with the matter with an aim of assisting her to decide what to do by stating that discussing the matter further with her father would help outline her fears and frustrations. She was made aware that she needs to bear in mind that she still needs work that could help her to earn a living in order to start her own business. Her answer was that her father is not easily approachable and this was of course taking her a step backwards as she was proceeding well so far. Her task for the last session was to imagine future difficulties and how to deal with them.

Comments: She showed good progress as a result of the coping strategies that were taught and that seemed to be effective in changing the negative way she had perceived her disease, because she stated: “I no longer see myself as a sick person now. I feel as if I am now born again and I am going to live a normal life like any other person. There is nothing that is going to prevent me from achieving what I have planned ...” She further pointed out that she regards herself as a role model to many people, even to her father. Her assigned task facilitated change in a positive way and worked well in changing her negative behavioural patterns. It

was evident that she was now familiar with homework assignments and coping strategies as she seemed to be future orientated. The problem-solving skills and the advantages and disadvantages techniques seemed not to be effective as she appeared to be finding it difficult to decide about working for her father and possibly needed time to think of these skills and find them to be useable.

Session 8

Coping strategies were reiterated in this session with the aim of further enhancing her coping skills. Her assigned task about imagining future difficulties and how to deal with them was discussed and she commented that she would need to be one of the successful business women. So her biggest fear would be what if she did not make it, because she was now living with the disease. She indicated that she has told herself that even if she fails, it is okay, because she may not succeed at once. Positive cognitive reframing was taught when the researcher said: “even if you fail, that should not be seen as a failure; it should be regarded as one of the challenges that you were faced with and you should still strive to be successful. You can only be successful if you have tried something in life, otherwise you will never know where your strengths and weaknesses lie”. She responded: “you have helped me a lot to cope with the current situation, especially my family who was rejecting me. Fortunately I have seen my father starting to show more of an interest in me, because he is now eager that I should assist him in his shops”.

Coping strategies were taught to show her that she can still learn from her father as he could be one of the people he could be talking to in order to establish how he has managed to make it in life, since she indicated that he runs a successful business. She replied: “yes, the other thing that I plan to do is to assist my father at his shops in order to earn some money so that I can start my own small business as you suggest. I would then leave him as soon as I have enough capital to start my own business”. The researcher followed up on the previous problems she encountered with her father and she stated that she talked to him and he has promised to sort out the problem. She mentioned that she knows that it was not going to be easy, but she has prepared herself for the worst because she has come to realise that she needs to achieve her goals like any other person.

Further coping strategies were presented when the researcher reminded her that setbacks are normal, especially when living with the virus. She was encouraged to continue living a positive lifestyle that would help her to live longer and continues to think positively; adhere to the treatment regimen and practise safer sex.

Comments: Coping strategies that were recapped proved to be effective in assisting her to deal with stigma. For example, she remarked: “I am further dealing in a better way with regard to the stigma and discrimination that come

from other people, and I would like to thank you for that, because I am already coping. I am also able to talk to other people and educate them about HIV/AIDS". Her homework assignment proved to be effective in assisting her to have a positive view of herself and to learn to anticipate, and deal with the problems she might come across pertaining the disease. She appeared to have changed her perception of internalised stigma and discrimination that was facilitated by positive cognitive reframing, and therefore therapy was terminated.

Overall discussion of participant 7

Overall, it can be noted that graded task assignments did not work well as it was difficult to give this assignment. This is because she did not understand the technique and reacted by becoming silent and just saying: "yes". Problem-solving skills did not either prove to be that effective maybe because she had many things to deal with other than her diagnosis. The advantages and disadvantages technique was also not effective as she possibly needed time to think of this skill and find it to be useable.

Strategies that proved to be effective were homework assignments that facilitated change in between sessions in a positive way. Positive cognitive reframing worked well to change her negative thinking about the disease, and this also contributed to a positive behaviour change that started the change process. Socratic questioning and reality testing were also effective to change her thinking as she initially used to blame herself for living with the disease and she realised that she did nothing wrong to contract the disease and had to live her normal life.

The technique of identifying, challenging and changing negative automatic thoughts and assumptions also proved to be effective as she could monitor such thoughts and knew what to do when faced with them. Coping strategies were effective in assisting her to cope and live a normal life. Assertiveness training and social skills training that was taught through role-play proved to be effective as she could assert herself in her interaction with others and talk to them about her status. Decatastrophising techniques assisted her in re-evaluating, modifying and changing her fears about what would happen if she disclosed her status to others, as she disclosed to her cousin, which showed that she gained more insight into handling her situation.

It can be noticed that the intervention was a success in this case because therapy enabled the client to deal with her negative automatic thoughts such as guilt, fear of death, anger directed at herself, suicidal feelings, depression and feeling rejected by family members. The victory of the participant in terms of being enabled to deal with stigma was the manner in which she changed her perception of HIV and regarded herself to be similar to others – hence she started talking about the disease and faced the challenge of a family not accepting her. This had a positive impact on her behaviour, which was also confirmed by the quantitative instruments post-therapy. The participant scored

less on depression (40 before which is severe depression to 8 afterwards which is considered in the normal range), less on internalised stigma (36 before; 20 after), less on enacted stigma (7 before; 4 after), higher on self-esteem (14 before; 2 after) and had more positive ways of coping (26 before; 41 after).

Participant 8

Session 1

1. Context

The participant is a 24-year-old woman who was seen at Witbank Hospital with an aim of assisting her to deal with stigma and discrimination related to HIV/AIDS. She was referred by the nurses and was requested to participate in this research, to which she agreed. She indicated that she lived with her fiancé and her child. Her mother was reported to be living in KwaZulu-Natal with her siblings, while her father had passed away. She mentioned that her partner and the family members knew about her HIV status. Most of her stress originated from her partner who did not want to be tested for HIV and refused to use a condom when they engaged in sexual activity. She further indicated that her partner threatened to kill her or part ways with her if she were to continue insisting on using a condom. She mentioned that she received most of her support from her mother.

The client indicated that she became scared upon learning about her diagnosis and had chronic worries about death, as she said: "... when I was told that I have contracted the virus, I was scared and feared death. I was hurt and thought that I was going to die soon ..." Her diagnosis had an impact on her life and her body image and she stated: "... I drastically lost weight but I am better now as I am gaining weight".

The woman seemed to be denying reality about living with the disease. She also seemed to be affected by the stigma and discrimination surrounding HIV/AIDS, because she said: "... that hurts me a lot ... it hurts me so much. People think I have contracted this virus because I am immoral. It is as if I just have sex with any other person or sleep around. It does not mean that I have contracted this virus because I was sleeping around". She further reported to be experiencing stigma since she was called bad names by people because of this disease and that made her angry.

She stated that she had lost confidence as people were rude to her, especially in church, because she was living with the virus. As a result, she mentioned that she no longer sang in the choir at church because the church perceived HIV-positive people as those who were sleeping around. She said: "... my self-esteem has really been affected and I do not want to lie about this ... the reason for it is that some people are rude to you, saying that you are nothing because

you live with the disease. That makes me afraid and fearful and I lose lots of confidence and no longer trust myself. I used to sing a lot in church but my confidence is undermined as people say bad things about people like us. They used to know that I will sing in all the choirs, but since I have contracted this virus I have lots of fears and I no longer have confidence in myself". It was evident in this case that the client was experiencing internalised stigma.

2. Definition of the relationship with the counsellor/researcher

She presented herself in a one down position by putting herself in the position of a follower and maintained that throughout the therapeutic relationship.

3. Distance (Punctuating from the participant's point of view)

3.1 Acceptance of reflections

The interview started with a distance because she spoke about her situation in an intellectual way. That changed as therapy progressed to an appropriate distance because she was accepting the researcher's reflections of her feelings.

3.2 How did she express herself?

She initially spoke about her HIV diagnosis in an intellectual way and expressed very little of her emotions. That changed as therapy progressed. She indicated to be harassed and treated badly by her partner. She also kept on blaming mainly him for contracting the virus, though blaming herself too.

3.3 Manoeuvres and behavioural patterns

A pattern of fluctuating distance was observed throughout the relationship. She manoeuvred for distance when she spoke about her situation in an intellectual way and manoeuvred for closeness when she accepted feelings that were reflected and gave details of how she was being discriminated against.

4. The client's support system

Her support system consisted of her mother, siblings, fiancé and her child. It was evident that the relationship between herself and the partner was symmetrical and characterised by ongoing conflicts, as he was treating her badly and forced her not to use a condom when engaging in sexual activity. While her partner was reported to be treating her badly, she stated that she received moral support from her mother.

5. Hypothesis

Because of the stigma and discrimination she was experiencing, she felt rejected by her partner and therefore depressed, hopeless and helpless. This could be because she realised that she was not adhering to the treatment regimen by not using a condom and yet her partner refused to use it or to undergo testing. Her interactional style was that of a person who is doubtful and thinking of herself as defeated and helpless, hence not certain of what to do about the stigma she comes across. This was also exacerbated by the fact that she thought no one understood what she was going through, especially the elderly people at home. Her interactional style had the effect of distancing her from others; it also caused her to feel hesitant and uncertain of how to handle the discrimination she was faced with.

6. Symptoms

Due to the stigma and discrimination, as well as the bad treatment she received from her partner and the church members, she tended to become depressed, doubtful and uncertain of how to deal with her diagnosis.

7. Goals of therapy

The goal of psychotherapy was to equip her to deal with cognitive distortions, which caused her to experience stigma. She intensely experienced stigma and needed to learn how to deal with it in order to cope effectively in her environment.

8. Type(s) of intervention used and the reaction of the client

The woman's self-confidence seemed to have been affected as she previously indicated. This was as a result of people's negative comments when living with the virus. Her negative automatic thoughts and low self-esteem following her diagnosis were challenged in this session. For example, the woman was shown that people's remarks should not weaken her confidence as it was not lowered before her diagnosis with this disease. She responded by nodding her head, which implied that she was agreeing with this suggestions. She seemed to battle with this technique because it was unfamiliar to her and she possibly needed time to think about these suggestions. Given her lower level of self-esteem, she was assigned to reflect on the things that would improve her confidence.

Comments: Not much change could be attributed to the identifying, challenging and changing of negative automatic thoughts and assumptions, given the fact that this was the first therapeutic encounter with her and everything was new to her. More time would have been devoted to this technique until she grasped it.

Session 2

Her feelings of powerlessness, which included loss of self-worth, were discussed in this session, as well as her previously assigned task and she reported that she needs to surround herself with people she can benefit from, so as to get proper advice and also to boost her self-confidence. She added that she does not hide her HIV status, especially with males, as they often like to propose. Her partner was reported not to be understanding that she emphasises using a condom. The researcher educated her by pointing out that adhering to condom use will help to prevent the spread of the infection and to prolong her life. She stated: "I must admit, though, that I often think that it is best to get a man who is in the same situation (*HIV positive*) as you, as he will abide by all the given rules because others may not understand. They like you if you are a bit soft and they need to control you not to use a condom at all, hence I say it is not easy. You should not listen to him saying that he loves you, as he wants you not to use a condom".

Assertiveness and social skills training were taught through role-play in order to equip her to deal with the partner who refused to adhere to treatment rules. She was encouraged to use the condom at all times irrespective of how convincing he was and not compromise the way she was taught, as she needs to assert herself given her HIV status. She was taught to say "no" when it is applicable and stand for her rights by prioritising herself first. Her answer was: "yes, because if you listen to all he has to say to you, you could feel pity for him (*the partner*). Hence, you will end up fulfilling that person's wishes and needs but not your own".

A few coping strategies were taught such as having no control over people's remarks but having control over how she deals with such talk, especially being discriminated against by other church people, which lowered her self-confidence. She was shown that she does not have control over people's remarks. However, she has control over how she manages such talk. The researcher further presented some coping strategies: "now that you live with the virus, you should still see yourself as achieving your goals and future plans". She appeared to be agreeing with this line of thought.

Socratic questioning and reality testing was taught to help her deal with people's remarks (singing in the choirs at church and she lives with this disease) which lowered her confidence. For instance: "now that you are diagnosed, how come that your confidence is lowered, as you were still singing in church whilst living with the virus but you did not know by then?" She agreed by nodding her head. A positive cognitive reframing was taught to enable her to have alternative ways of interpreting her diagnosis. She was encouraged to have a way forward as she never had a choice about contracting the virus but rather to focus on alternative ways of appraising her situation. She reacted: "yes, it is important that I should never look backward but look forward to what can help me. It will indeed be

better if I focus on what will help me”. Her homework for the next session was to monitor all her negative thoughts by writing them down.

Comments: She showed progress in the area of gaining self-confidence as a result of the homework that she was given for the previous session and that proved to be effective, as it started the change process because she stated that one should also not hide her status especially with males who like to propose. Assertiveness and social skills training that was taught through role-play worked well to give her hope in dealing with her abusive partner. A positive cognitive reframing appeared to be effective in assisting her to examine options that were presented to her, as she commented that she will focus on what will help her. She still found it difficult to learn the technique of Socratic questioning and reality testing, as she responded by nodding her head. As such this technique seemed to be not effective. Coping strategies taught also proved not to be effective as she responded by saying: “yes”.

Session 3

This session focused on how she experienced the reaction of others, given the stigma she was encountering especially from church members, and given the fact that she was treated badly by her partner. Her assigned task was explored in this third session and she reported that her partner was forcing her to engage in sexual activity without using a condom. She added that she did not allow him to rule her and was warning him that he was harassing her and that she will open a case against him for such behaviour. Her partner was reported to have not been tested since he did not want to. He was not even thinking of knowing about his status because he told himself that he does not have such a disease as he was physically well.

Assertiveness and social skills training were presented in order to equip the client to deal with her partner’s bad attitude. For example: “remember to consider yourself first, because if you do not do that, you may destroy your precious life. It is okay to stick to the way you feel about things and assert yourself in your environment by not being scared that you might lose him”. She was educated through positive cognitive reframing on how to perceive and deal with people’s negative remarks: “it is important to have a look at your situation in a more positive way, as you are given a chance to live longer and it is up to you to decide how you utilise such a chance. Even if people at your church discriminate against you, still regard yourself in a positive way”. Her response was: “what I want to add is that if you know what you want in life, you may not be easily disturbed. If someone wants to deceive you, you will easily notice that, since you will be focused in whatever you are doing”. Her assigned task was to consider her future plans for the next five to ten years.

Comments: She appeared to be doing well and to be developing assertiveness training as therapy progressed, especially in handling her partner who refused to

use a condom. Her homework assignment proved to be effective as she could identify that her negative thoughts were mainly emanating from her partner's lack of understanding to use a condom. Positive cognitive reframing also proved to be effective in changing her thinking to become positive, as she seemed to have purpose in life and believed in what she wanted to achieve.

Session 4

Her uncertainties about the future were explored, given the stigma and discrimination she was experiencing. Her homework assignment, namely to consider her future plans for the next five to ten years, was explored as she indicated: "I need to take care of myself and succeed, as I do not want to fail. I need to get employment and wish to go on with what I have planned to do such as helping other people not to land in the same situation as I". Despite the bad treatment she was receiving from her partner, the researcher noticed that she was still hopeful about life.

When asked if there were other issues of concern she wanted to talk about, she mentioned that her partner was still abusive to her and she went to the police station to report him as he was against using condoms. Her partner even threatened to kill her if she did not adhere to his instructions and that was hurting her the most. Assertiveness training was further taught to assist her to manage her partner. She was once more shown that her life comes first and was required to decide what she needed to achieve in that relationship, because she often complained of being abused emotionally. The client was made aware that continuous abuse might drastically affect her psychological well-being. She replied: "yes, I even tell them at the police station that I live with the disease and I do not hide anything from them. I am not ashamed of talking about it. They even wrote him a letter requesting him to come to the police station".

The researcher further trained her to consider different ways of thinking about her current situation through positive cognitive reframing: "you need to have a way of handling this. Think of how it will help you to continue with this relationship; maybe this could be a turning point in your life as it may reduce your stress level. He can also be referred for professional help if he will agree to that". She commented further: "what I think is that I should consider parting ways with him so that I have peace in me, instead of being emotionally abused". Her homework for the next session was to consider what was to be done with regard to her abusive partner, seeing that he was causing her stress.

Comments: She appeared to be progressing well as a result of the homework assignments, which facilitated her positive thinking, because she seemed to be determined to achieve her plans about taking care of herself and helping others deal with stigma, despite her ongoing abusive relationship. Positive cognitive reframing skill that was taught about her abusive partner worked well, as she mentioned: "... if you part ways with a person, it does not mean that it is the end of the world". Assertiveness training proved to be effective too as she seemed to

be determined to adhere to condom use. The reason why these strategies were effective is that she could understand them well as they were presented and a few of them were suggested at a time.

Session 5

The participant's feelings of guilt, which included anger that was directed inwardly, and the partner's abuse were addressed in this session. Her homework assignment, namely to consider what was to be done with regard to her abusive partner was discussed and she stated that it was not easy for her to part ways with him on her own as she came from far with him and thus she had to inform her parents. In addition, she mentioned that to be safe and secure, she applied for a protection order. She further said that she was looking for her own accommodation since she was being treated badly by him. She then indicated that she will therefore take a decision when she was with her parents at home.

Decatastrophising was taught to help her anticipate her parent's comments: "be careful of the fact that your parents would possibly like this relationship to go on and not come to an end. You still have to make a definite decision. Even if you try to explain your situation to them, they will possibly tell you that all relationships are like that".

Coping strategies were taught that the important thing in dealing with her abusive relationship was that she speaks to her parents as she earlier on pointed out. She was shown that they might understand what she was going through and tell her that she was the person to decide on things such as those - which might help her live a better life afterwards. She replied: "yes, I am just going to inform them of my decision because I have concluded that when I come back I will not reside with him and will stay on my own. They are of course not going to tell me that I should part ways with him, and I should be the one who decides what to do, as I am the one who is experiencing the pain. I want to live freely without any form of pain hurting me".

Her homework for the next time was to think some more about what is to be done with regard to the ongoing abuse from the partner, as it seemed to be the main thing that was bothering her at this stage. In addition, she was tasked to think of how she would inform the elderly people at home as they would perhaps not understand the decision she had taken.

Comments: She appeared to have gained from her homework task and the coping strategies that seemed to have worked well, as she had taken a particular decision regarding the abuse – as she wanted to live freely without any form of pain. Decatastrophising proved not to be effective in helping her to anticipate the worst in explaining her situation to parents maybe because she was not familiar to this skill and she needed time to understand it. Hence being tasked with this skill to go and practise more of it.

Session 6

Behavioural implications were explored in this session, as well as the task assigned at the end of the previous session. She stated that when talking to her family she will remind them of the first and recent protection order that she obtained against him because she was traumatised by him. The woman further indicated that his brother would also be a witness as he tried to talk to him, but it has been in vain. She said if they will ask about what will happen with the child since parting ways with him. She would tell them that if he was thinking and caring for the child, he would not have harassed her and he would support the child because he is working. When the family talk about dowry that was paid and think that maybe she had extra affairs (which she does not have) - she would tell them that her life was more important than dowry that was paid.

Some problem-solving skills were taught to further empower her to deal with her family in case they doubted her parting with her partner. She was informed that she could even ask them to call the police station for further clarity. Her answer was: “yes, because that makes me feel bad and feel regretful for having met him”. She was further enabled to deal with her current situation by applying coping strategies when the researcher said: “be careful that your abuse does not result in you pitying and isolating yourself, and in you ending up neglecting yourself. You need to deal with such behaviours as early as they are occurring to you. Know what to do while you still have time and can deal with it”.

When asked about other issues she wanted to raise, she stated that she was thinking that he is just treating her badly because he knows that she will not leave him because she was unemployed and he might think that she relies on him with regard to money. She believed that God will see her through and she did not want someone else to think on her behalf and control her future. She was educated on positive cognitive reframing to help her think of the future in a positive way: “you are responsible for your future plans, not someone else. You can make your future to be as bright as you think it will be. It could be the way you want it to be, but not how your fiancé wants it to be ... and not how your parents want it to be, even if they are being supportive to you”. She was asked to reflect on how it would help her to pity, isolate and neglect herself, given her current diagnosis. The aim of the assigned task was to make her realise that there were better ways of dealing with stigma and to assist her not to pity herself given her partner’s ill treatment.

Comments: She seemed to be at ease with regard to implementing the coping strategies and problem-solving skills, and they proved to be effective, as she mentioned to have planned to live the type of life she wanted to live all along. Her homework assignment proved to be effective in assisting her to devise a plan to stop the ongoing abuse. Her faith in God was also important in giving her hope and brought change in her as she was in the process of ending the abuse. Positive cognitive reframing proved not to be that effective as she only

responded by saying: “yes”. More time could have been dedicated to this technique in order to effect change. Even though she only said: “yes”, she was already thinking of what was suggested because she was taking control by planning to leave her partner.

Session 7

Her assigned task, namely to reflect on how it would help to pity, isolate and neglect herself, given her current diagnosis, was explored and she stated: “...that is not going to help me at all because I have to take care of myself. My quality of life would go down if I do not do that and I would further think of lots of things I should have done. I do not have to think of bad things, but rather of positive things that will happen to me and take me forward. I am going home today to explain to them about my current situation. I do not want to go backwards but I want to live happily”. It was observed in this instance that the client was determined to end the abuse in order to live happily.

Coping strategies were a focus of this session as the researcher said that feeling pity for herself was not going to help her, rather what would help was the fact that she wanted to live because she noticed that she cannot change her status but can change the way she dealt or coped with it. Other coping strategies focused on using the time she was left with effectively to accomplish her goals. It was also important to remind her that setbacks are normal when living with this disease. Her response was that she needs to acknowledge the fact that she is experiencing stress and that leaving her partner will help her to cope and that she should look ahead to the things that should help to go forward.

A decatastrophising technique was taught to prepare her for the worst that could happen when she would speak to her family about parting with her partner. The researcher assisted her to anticipate the worst when he mentioned that her family may not understand that she refused to have sex with her partner and that she only agreed to it when using a condom. The family would remind her that she is married customarily and needs to respect him and obey his instructions. Decatastrophising was used in this session to prepare her for the difficult task of dealing with future difficulties she might come across.

Comments: As a result of the coping strategies that worked well, she appeared to be managing and seemed empowered to handle the ongoing abuse. For example, she said that she had come to realise that she would need to do something about being treated badly by her fiancé, because she wanted to live happily. Based on her comments, it can be noticed that a positive impact of therapy was seen in this session. She was able to understand and accept the principles taught in her homework assignment and this worked well to facilitate change in respect of her feelings of self-pity – as she noticed that it would not help to pity herself instead of living her normal life. Decatastrophising proved not

to be effective as she reacted by only saying: “yes”. More time could perhaps have been given to this technique to ensure that it would work well.

Session 8

In this session the imagined future difficulties she might come across and how to deal with them were explored. She stated that she explained to the family about her being treated badly by him. She took all her possessions away from where she used to stay so that she would not have to come back. They needed someone else to give evidence of what she was saying because they did not believe her much and she told them of his brother, her brother and the people at the police station. When they further asked about the dowry she told them that he knew very well that what he was doing would make them separate. She added that the dowry seemed to be important to them, but it was not as significant as her life because it cannot buy it and cannot even help her to persevere. They then realised and took cognisance of what she was saying all along.

She further said that they asked if she would not date men in future and she stated that it was important to live a healthy life and adhere to all the given instructions. They were further interested in knowing where was she going to stay since she was not working and she told them that God has given her hands to work for herself since she had attended sewing lessons and has acquired the necessary skills. They had heard her complaints and then admitted that he was wrong. Her mother was reported to have even said that because of all the sickness that she had gone through, he should have been kind and should have shown mercy towards her. She then realised that she had driven her point home, because her mother could understand her.

Assertiveness training was taught to further assist her in asserting herself in her interaction with others. For example: “of importance is what you do to end the pattern of abuse. Your family could continue to say you need to persevere, but it is important to note that you are the one who is experiencing bad treatment. Continue to be assertive by saying no to abuse. For the sake of your better future, you need to adhere to what you were taught and say no to sex without using a condom. By being assertive, you will assist yourself to accomplish what you want in order to live longer”. She appeared to be agreeing with this line of thought.

Coping strategies were repeated in this last session to teach her to handle social problems more effectively. For example: “you have the support of your family and that will help you to go on, despite the difficulties you have. Establishing a more adaptive and functional way of responding to internalised stigma and discrimination would benefit you”. She stated that she was not rude to her family, but she needed them to understand what she was going through. She indicated that she was encouraging family and relatives to undergo testing, and was trying to show them that one can still live with this disease.

Comments: She showed good insight into the coping strategies that worked well, because she wanted her family to see her as a role model and to show them that she would not allow her partner to abuse her. Assertiveness training proved to be effective because she could assert herself in her environment. The homework assignment that was given in the form of a decatastrophising technique proved to be working well, because it assisted her to anticipate the worst with regard to talking to family. It was at this stage of therapy that the researcher realised that the participant had fully grasped dealing with stigma hence the therapeutic relationship could be terminated.

Overall discussion of participant 8

To summarise, it seemed as if the techniques of Socratic questioning and reality testing, identifying, challenging and changing negative automatic thoughts and assumptions did not have an immediate effect on the client as she only reacted by nodding her head. However, this was at the start of therapy and may have contributed to her thinking differently in later sessions. If these techniques were repeated later in therapy, she could possibly have grasped these skills more effectively.

However, the technique of positive cognitive reframing proved to be effective in changing her thinking to become positive, as she regarded herself to be similar to others, and when she started to think that way about her diagnosis everything changed since she was now talking to her family about the disease. Her homework assignments proved to be effective and facilitated the change process. Teaching coping strategies worked well because these skills enabled her to live a happy life she wanted to live all along and to help others to cope with HIV. Problem-solving skills worked well too to help resolve her ongoing abusive relationship, as she mentioned that parting ways with him does not mean that it is the end of the world. Decatastrophising technique also proved to be effective as it helped to prepare her for the worst before going to speak to the family about her abusive relationship. Assertiveness and social skills training that was at times presented through role-play proved to be effective, as it gave her the insight to handle her partner who refused to use a condom and she was able to assert herself when talking to her family.

The researcher felt that this was an interesting case as much change was observed on psychometric evaluation post-therapy, which strengthened the qualitative information. The findings indicate that the woman experienced less scores on depression (19 before which is borderline clinical depression to 9 afterwards which is considered in the normal range), less internalised stigma (32 before; 27 after), and her self-esteem scores (4 before; 0 after) improved significantly after having participated in eight therapy sessions.

Participant 9

Session 1

1. Context

The participant was a 35-year-old woman who was HIV positive and was seen at the Wellness Clinic for assisting her to deal with stigma and discrimination. She was referred by the nursing personnel and showed willingness to take part in the study. She reported that she came from a family of six children and lived with her parents, two sisters and their children, who all knew about her HIV-positive status. She stated that she had no children. No other people were indicated to know about her status except her family. Her partner was reported to have left her when he discovered that she was HIV positive. She said: “I used to have a partner but since he discovered that I am sick (*referring to HIV*) he distanced himself”.

She could neither eat nor sleep when she was told to be HIV positive and had lots of anger directed towards herself and God. She blamed God for contracting the virus. She had regrets about living with the disease, as she said: “at times I think that I wish God could not have given me this disease ...” Her HIV diagnosis changed her lifestyle with regard to intimacy because she pointed out: “... I no longer have intimate relationships ...” She stated that she had chronic worries about dying soon because of living with this disease. She furthermore experienced suicidal ideations following her diagnosis. She mentioned: “that happens a lot ... I then think that it is best if God can take me as I see no reason for living ...”

The client’s self-esteem was low and she indicated to have drastically lost weight at the time she was diagnosed with this disease. Her sister was reported to be discriminating against her by making bad remarks about her HIV status. They usually argued a lot. The rest of the family members were described as being supportive. She stated that she coped by disregarding people’s negative comments and denying reality about living with the disease. For example: “even if people talk, I do not consider that much as that will make you to feel sick. Tell yourself that that is not a problem and it will pass by”. She further stated that she coped through distancing and distraction, which included playing games on her cell phone, watching TV and DVDs whenever she thought of this disease.

2. Definition of the relationship with the counsellor/researcher

The participant entered the relationship in a one down position and maintained that throughout the therapeutic relationship. She maintained eye contact during therapy and her tone of voice was soft and low.

3. Distance (Punctuating from the participant's point of view)

3.1 Acceptance of reflections

The woman maintained an appropriate distance throughout the therapeutic relationship and she did that by accepting reflections of feelings.

3.2 How did she express herself?

She spoke about her diagnosis in a transparent and congruent manner, and presented herself in a depressed and helpless way. She did that by giving details about her diagnosis and blamed herself and God for contracting the virus.

3.3 Manoeuvres and behavioural patterns

A pattern of closeness was maintained throughout the therapeutic relationship. That was observed when she accepted empathic reflections of feelings and manoeuvred for support and understanding when she spoke about her HIV status in a helpless and defeated way. Her behaviour could be interpreted as learned helplessness.

4. The client's support system

Her primary family system was made up of her parents and five siblings who were stated to give her moral support, except one sister, who made bad remarks about her living with the virus.

5. Hypothesis

It could be hypothesised that she was experiencing internalised stigma and discrimination due to her sister and other people talking negatively about people living with HIV/AIDS. She was suicidal, depressed and angry, and blaming herself and God for contracting the virus. She tended to perceive herself negatively and generalised all negative feelings to be related to HIV. Her interactional style had the effect of distancing her from others and thus led to her experiencing suicidal thoughts and a low self-esteem.

6. Symptoms

Her suicidal ideations, low self-esteem, fear of death, anger and depression mainly resulted from stigma and discrimination that was internalised. That was caused by others and her sister who said bad things about HIV-positive people. Her symptoms could also originate from the fact that HIV/AIDS was viewed in relation to issues of death, moral judgement, religious punishment and a failure to follow cultural traditions as identified in other African communities (Aggleton &

Chase, 2001; Bond et al., 2002; ICRW, 2002c; Kopelman, 2002; Niehaus, 2006). Her ongoing quarrels with her sister also possibly contributed to these symptoms.

7. Goals of therapy

The aim of psychotherapy (CBT) was to empower her to deal with cognitive errors and to assist her to optimally function and change her perceptions of internalised stigma and discrimination.

8. Type(s) of intervention used and the reaction of the client

She appeared to be worried about dying soon as she stated in this session: "... it is at times difficult for me when I think about this disease. I would ignore such thoughts, as if they do not exist, as they stress me a lot. I often would think that one could any way die at any time because of this disease". Her negative automatic thoughts about dying at any time were dealt with through Socratic questioning and reality testing with an aim of changing her thinking and challenging the validity of the cognitions. For example: "were you constantly thinking about death before you were diagnosed with this disease?" to which she replied: "no". The researcher further challenged her negative thinking when he said: "how come that you should be thinking about death every now and then, now that you live with this disease?" Her answer was: "I hear you there". The participant possibly found this technique to be new and unfamiliar to incorporate in her life. Given her tendency to consider suicide following her diagnosis, she was tasked to find a reason for living.

Comment: Not much could be said about the impact of the Socratic questioning and reality testing technique to question automatic thoughts as this was the initial session and the participant was not yet common with CBT.

Session 2

The focus of this session was on the participant's feelings of powerlessness, which included loss of confidence. Her previously assigned task was explored and she indicated that she should teach others about this disease, now that she was HIV positive. She stated that she should use a condom all the time and have one partner that she needs to disclose her status to. She furthermore mentioned that she needs to eat a balanced diet to boost her immune system and avoid alcohol, smoking and drugs. Since she started using the anti-retroviral treatment, she wanted to continue using them for the rest of her life so as to live a normal life with this disease. It could be noticed that when she started to think differently about HIV, everything changed.

The researcher further explored her homework assignment and she pointed out that she needs to make her dreams come true, as she has graduated. She needs to see herself getting work and have a house and being free emotionally, living

her own life and going forward. Positive cognitive reframing that was presented focused on discrimination as she pointed out that other people discriminate against her. She was made aware that she does not have control over such people's remarks, but she has control over how she perceives such talk. It was also explained to her that people's talk should also not lower her confidence.

She was further educated to perceive her current diagnosis in a more positive way when the researcher stated that as a person living with the virus she has to see herself and the virus in a positive way. She replied: "as you said it ... I will start to disregard and ignore whatever people say, as I told myself that I know my status and whoever talks about me probably does not know about his/her own status. That is why I want to focus on my future and not tell myself that I will not be able to accomplish this and that because I have the disease. I should regard myself as living a normal life".

A few of the coping strategies were taught to assist her to realise the things she can change and those she cannot change about her diagnosis: "as you are on treatment, you will realise that some days you could be fine and other days not. This should not influence your confidence and self-worth, but you should be in charge of your situation. She seemed to be agreeing with these suggestions.

Decatastrophising was taught to help modify the worst thing she thought could happen about people's bad remarks. For example: "you need to be prepared for the worst by expecting people to make bad comments since you are living with the virus. As such these remarks should not be seen as easily affecting you when people make them to you". She responded by nodding her head. She was assigned the task to consider what would lift her level of confidence when faced with people's negative comments because she was living with this virus.

Comments: Some coping strategies that were taught appeared to be effective towards the end of therapy and this was noted when she stated: "my self-confidence has started to increase since I started to see you last week". Her assigned task proved to be effective as she had reasons for living and it also facilitated change as she wanted to achieve her goals by helping others with this disease. Positive cognitive reframing proved to be effective in assisting her to think in a positive way about her future. Decatastrophising technique proved not to be effective yet as she was observed to be struggling to grasp it and only responded by nodding her head. The reason why this technique did not work well could be that more time could have been devoted to it in order to make an impact in her life.

Session 3

The participant's guilt feelings, which included anger directed inwardly in the form of suicidal ideations, regrets and negative self-evaluation, were explored in this session. Her previously assigned task was explored and she remarked that she

needs to think positively about herself, which is hard to do and set certain goals for herself. She needs to know better about her personal strengths and weaknesses in order to help other people who are struggling. Her other goals were to finish her Human Resource Diploma. The stumbling block she mentioned to be experiencing was that she received regret letters when applying for work and she thought that it could be because of her HIV status.

Positive cognitive reframing was taught to help her think of other ways of viewing her failures with regard to not getting employment. For example: "it is important to know that you need to view your status in a different way and not think that you are not employable because you live with this disease. So continue to send applications to as many companies as possible, as you may never know where you will be accepted despite your status". Her response was: "I will not give up on my dreams and faith. It means that I must try at all times to be more positive in life. I should not give up dreaming about my goals". She added that there are other people who have finished school long before her and are still looking for work. She further said that she should tell herself that she should utilise that part-time job that she received to gain experience, with an aim of getting proper work next time.

Some coping strategies were taught to assist her to deal with her stigmatising thoughts about HIV and she did not engage with the suggested ideas, therefore, the researcher did not know if she understood. Her assigned task was to identify negative automatic thoughts she was experiencing and how to handle them.

Comments: Her homework assignment proved to be effective in helping her to think in a positive way and to set goals for herself. Positive cognitive reframing proved to be effective in assisting her to realise that her applications for employment were not being rejected because of her status, and she appeared to be determined not to give up on her dreams. At this stage of therapy the participant was noted to be changing the way she perceived her diagnosis and that started the change process. However the coping strategies that were taught proved not to be effective as she only responded by nodding her head.

Session 4

As a result of the stigma and discrimination she was encountering, behavioural implications such as self-pity were explored. The task assigned for this session was discussed and she reported: "I feel guilty and I blame myself. I think why do I have to be the only one who lives with the virus in the whole family? I also wish to know when, where, from whom and how did I contract the virus. What did I do also to contract this?" It could be noticed that the participant was able to observe and record negative automatic thoughts.

Her cognitive distortions about her being the only one in her immediate family and relatives living with the virus were discussed when she was made aware that

it is important how she deals with her HIV, as she was probably not the only one in the family who had this disease. Others may have been tested and have not disclosed their status yet. It was mentioned that it was not her fault that she contracted the virus and she should not blame herself for it. Blaming herself was not going to help to get rid of the disease, because she had it and cannot change her status (identifying, challenging and changing negative automatic thoughts and assumptions).

She was further taught positive cognitive reframing to assist her to look for alternative ways of appraising her diagnosis and to view it in a positive way. For example: “you are not the only one suffering from this disease, as you can see here at the clinic. You possibly need to challenge your thinking and look on the brighter side of things and continue to live as you did before being diagnosed”. She replied by saying: “I agree with you there, as I am continuing to live my normal life. I sometimes get scared if I have a common cold. I worry that maybe I will fall asleep and that could be my last day, and that prevents me from sleeping well. I tell myself that if it is not yet time to die, I will not die”. Challenging of negative automatic thoughts about the fact that she might die at any time were discussed. For instance: “you seem to be over-generalising when small issues happen to you, because all of us at some stage become sick. You have this disease and you will continue to suffer from other diseases. Any other person suffers from these common colds and it does not necessarily mean that if you have it, you will die, therefore go on living”.

She pointed out that she does not like to argue with people, as it does not please her because she quarrelled with her sister who told her that she is 100% healthy as she does not live with the disease. Decatastrophising was taught in order to prepare her for the worst in dealing with people’s negative comments. For instance: “you should expect the worst with regard to being discriminated against by your family or any other person. Not all the people will show empathy and understanding of your current situation, and therefore you should expect it”.

Role-play, which involved assertiveness and social skills training, was demonstrated to equip her to handle her sister’s discrimination against her: “avoid a lot of arguments with her, as this will possibly result in stress. Talk to your sister in a polite and assertive manner and say only one thing to her, as that might help to reduce the arguments you often have. You can possibly tell her that you understand what she is saying and that you never chose to contract this disease. Say it over and over without being rude to her”. She responded: “I can hear that; I also used to feel like crying in most cases and I often would cry. However, I am better since I have started seeing you. I will often do other things such as watching TV and DVDs and that also helps me a lot as I avoid these negative thoughts coming to me”. In this case, it could be recognised that she was using distancing and distraction methods to cope. Her homework for the next session was to think about how it would help to isolate and pity herself due

to her HIV diagnosis and people's negative comments. This task was assigned to help her realise that such behaviour would play no significant role in her life.

Comments: It was evident that the participant was able to gain from her homework assignment about identifying the negative automatic thoughts she was experiencing. The techniques of identifying, challenging and changing negative automatic thoughts and assumptions proved to be effective. These skills worked well in making her notice the source of her distress. Positive cognitive reframing worked well in changing her perception of HIV as she stated that she was continuing to live a normal life. She appeared to be hopeful with regard to assertiveness training that was taught through role-play and that made a positive impact in terms of handling others, in particular her sister. The distancing and distraction methods that she used for coping appeared to be effective and enabled her to get some distance from the constant flow of maladaptive thinking as she would watch TV and DVDs. Decatastrophising proved not to be effective. The reason for failure was that there were possibly too many strategies that were presented at once, instead of a few that she could easily have grasped and more of behavioural techniques could have been used.

Session 5

This session aimed at addressing the client's experience of the reaction of others as a result of stigma and discrimination. Her homework was explored and she said: "I do not have to ignore myself and I have to do what I desire to do and do it well, and not feel pity for myself. I have to continue with my studies and find employment. I also want to drive my own car one day and I tell myself that these things are possible".

Positive reframing was taught to help her to focus on her goals: "you need to be focused on what to do now that you live with the disease. See it as another chance you have been given to live in order to accomplish your dreams ...". Her response was that she wants to pursue the goals that she has set for herself to achieve as a child, and needs to help others and see herself as a valuable person in the community.

She reported that she needs to accept her status as people were proposing to marry her at some stage and she was still finding a way of disclosing her status to them. Decatastrophising was taught with the aim of preparing her for the worst when dealing with stigma: "you must also be prepared that such a person to whom you have disclosed may talk bad about you to others or discriminate against you; you need to expect such a reaction". She agreed by nodding her head and the researcher did not know if she understood as she did not engage in these ideas.

Assertiveness and social skills training, and anti-discriminatory laws were taught to help her further manage her sister's discriminatory actions: "you do not argue

with her but you speak in a polite and assertive manner. If others might possibly discriminate against you, remember that there are anti-discriminatory laws that will protect you from such harms”. She indicated that she has followed my suggestions and that if a person is talking to her she does not argue with such a person. She added that if a person talks and she does not argue with him/her, he/she appears to be foolish, because if you argue with him you end up fighting each other. Given the stigma she was experiencing related to HIV/AIDS, she was required to practise being assertive as her homework assignment.

Comments: Her homework assignment proved to be effective in enabling her to think positively about herself and changing her self-pitying behaviour. Positive cognitive reframing worked well in assisting her to perceive herself positively and pursue the goals that she has set for herself. Assertiveness and social skills training were effective in assisting her to change her thinking and behaviour as she was starting to assert herself in her environment. For example: “I now have a better way of handling that”. In this instance, she was referring to better ways of dealing with her sister who used to argue with her a lot. Decatastrophising technique was still not effective, as she was only agreeing by nodding her head – possibly because she was not able to fit this skill into her perception.

Session 6

Her uncertainties about the future, issues of concern to her, as well as homework assignments were addressed in this session. She had to be reminded of her assigned task and she indicated: “I would say that if there are people making me angry or being rude to me I would not be rude to them. If their voice goes up I would try my level best to lower mine. I do not have many problems between me and my sister since things have been sorted out now”. Assertiveness and social skills training were taught to further help the participant to assert herself in her environment especially when dealing with her sister.

She was taught positive cognitive reframing to further help her think positively about her diagnosis. For example: “you know that you did not choose to contract HIV and that approach will help you to deal with the stigma and discrimination that you are faced with on a daily basis. All that is important is that you know that you cannot change that, but you can change the way you view yourself”. She showed to be agreeing with this suggestion.

She was also taught some coping strategies in order to be empowered to deal with future challenges in a positive way when she was encouraged to continue living her normal life, while taking proper precautions where it was necessary. That could help her to have a brighter future since she will be avoiding lots of stress and will have a way of managing stress when coming across it. Using the social support to assist her in coping with her current situation was advised. She was shown that her family will help her when she was not feeling well, both physically and emotionally. She uttered: “... my family supports me more than I

was expecting. I do not leave problems unresolved as that hurts me most because I do not want to go to sleep being hurt. I have learnt to address things on the spot to avoid grudges”. She was tasked to consider her future plans for the next five to ten years.

Comments: Her homework assignment about practising assertiveness proved to be effective, although she had to be reminded of it. She commented: “I am now able to help others in a more polite way ... I also advise them so that if they are able to take my advice, they are then in a situation where they undergo testing”. Positive cognitive reframing assisted her to think in a positive way about her diagnosis. It seemed that she was receiving support from significant others, which proved to be effective in assisting her to cope. In addition, the use of social support from her family that was suggested as a coping strategy worked well, as she stated: “...I am no longer like before, as I am coping and have no problems. My life goes on as I wish it to ...”

Session 7

Her assigned tasks were explored in this penultimate session and she indicated that her plans were to take care of her health, think positively about life and practise safe sex. She did not want to feel guilty any more or have arguments with other people, since that made her to feel sad and cry a lot. She said that setting goals for herself would help her believe in herself and to know more of her strengths and weaknesses and to live a normal life like others. She was determined not to neglect herself and perceive herself as different from others, since she lived with the disease.

This session aimed at equipping the participant with coping strategies in order to deal with day-to-day stigma she was faced with: “I agree with you because you need to have the same positive attitude you used to have before being diagnosed. You possibly used to live with no guilt feelings and had self-confidence. Planning your life over the coming five to ten years will help you to go on. Remember that it is normal to have setbacks on other occasions; as such you need to have a way of dealing with such difficulties when you come across them”.

She responded that she wanted to see her CD4 count increasing to at least 500 or 800 and avoid any form of stress that will affect her health. She wanted to join AIDS campaigns such as the Treatment Action Campaign in order to acquire knowledge and to further distribute pamphlets to people so that they can be more knowledgeable about the disease. Her other goals were to encourage those infected to continue taking their ARVs on a daily basis and to adhere to eating a balanced diet, doing aerobics daily and avoiding fatty foods. She further said: “I would like to carry my friend, which is my treatment, in my bag all the time – even if I go on holiday. I would not argue with people and feel guilty or sad, as that would enable me to enjoy my normal life”.

Decatastrophising was taught with an aim of assisting her to visualise the worst things that she might encounter when speaking to others about HIV/AIDS. For example: “be prepared for people’s bad comments about stigma and discrimination and be aware that you cannot change the way they talk but you can change the way you deal with what they say about you. Have a way of dealing with them so that you are not affected when they make bad remarks about people living with this disease”. Decatastrophising was her assigned task for the last week – she was asked to imagine the worst thing that she might encounter and how to handle it.

Comments: She was coping as she seemed to be able to deal with the stigma and discrimination she was encountering. The coping strategies proved to be effective, as she indicated: “I want to educate as many people as possible to fight the disease. I also want to help those already living with the disease by encouraging them and giving them love”. It was seen in this instance that the participant was coping well because she was intending to empower others to deal with stigma. Decatastrophising proved to be effective in helping her face others: “I was shown the right way of living with this disease in order to cope and teach others who are in the same situation as I. I was further empowered not to be ashamed of my status and learnt to expect anything that might come my way”. Her homework assignment proved to be effective in enabling her to consider herself in a positive way as she stated that her plan is to think positive about life.

Session 8

Her homework assignment to imagine the worst thing that she might encounter and how to handle it was discussed and she pointed out: “... in instances where people are rude to me and discriminate against me I will ignore such a person. If that person confronts me, I will respond by saying that I never chose to live with this disease. If the person persists to discriminate against me, I will open a case against him/her since it is my right to do so”.

She was taught assertiveness skills such as educating her on how to talk to people when she was disclosing her status to them in an attempt to combat the spread of HIV/AIDS and help those already living with the disease. For example: “you do not have to argue with people because you are prepared to go and empower others about this disease. In that way, people will also know that you live with the disease and that you are possibly the person they are talking about. Have a way of responding to such remarks because you have volunteered to help others by disclosing your status”.

Decatastrophising was further taught to help prepare her for people’s bad comments as she would be continuing to talk to others about the disease. For example, she was prepared for the worst so that if that happens, she should be ready for it. If people were not rude to her that day, it should be fine. She was shown that people will not stop talking when she disclosed more about her status

and they will forever talk – so she had to make room in her thoughts or be prepared for that, so that if others are offensive and discriminate against her, she will have been ready by expecting such comments. She reacted: “what about those who overreact when talking to you? They will say that you should not tell me anything else and point at me, saying: ‘you are living with this disease and do not think that we all live with it.’ What should I do with such people?”

Coping strategies were taught with an aim of assisting her to further handle people’s discriminatory actions. The researcher suggested: “you do not argue with such people. They are possibly talking in that way because they have not undergone testing and they do not know about their status. Talk to the people who need help and not those who do not need it. People regard this disease in different ways; some are willing to learn and others may not be willing to learn about the disease”. She replied: “okay. There is a man that I told you about previously and he mentioned that he now requires my help because it is difficult for him, he phoned me yesterday to enquire about treatment for the disease”. It was evident that the client was coping as she was imparting her knowledge about HIV/AIDS to others.

Comments: She seemed to be coping and adjusting well, especially with regard to the decatastrophising technique that was taught as her homework. This helped her deal with people’s bad comments when living with HIV because she could anticipate their talks, as she mentioned: “people are of course going to talk and they may not be talking to me directly but they would talk about this disease”. It could be seen that she was now at ease with this technique. Coping strategies that were taught proved to be effective in empowering her to talk to others about her status and it was also evident that she was perceived by others as a role model, as they requested help from her. Not much could be said about the assertiveness technique as she did not engage with the suggested statements.

Overall discussion of participant 9

In a nutshell: It was evident that the technique that proved not to be effective with this participant was the Socratic questioning and reality testing, as she only reacted by nodding her head. That may have been at the start of therapy since she possibly understood many things. One reason why it was not effective was probably that the technique was presented at the beginning of therapy when CBT was still new to her. The other reason was that she also possibly needed time to digest it. Given such a limited time, that could have prevented her from grasping the skill.

However, the techniques that did prove to be effective were positive cognitive reframing which helped her to perceive herself positively and that facilitated a change process in assisting her to pursue her goals and playing a significant role in the community. Identifying the negative automatic thoughts she was experiencing worked well as she could observe and record such thoughts, which

implies that the method of identifying, challenging and changing negative automatic thoughts and assumptions was effective. As such that skill gave her the insight to notice the source of her distress and was equipped to deal with such thoughts when occurring.

Teaching coping strategies proved to be effective in encouraging positive coping as she was teaching others about HIV and was seen by them as a role model. Decatastrophising proved to be effective in helping her prepare for the worst in dealing with stigma she was experiencing especially from her sister. Her homework assignment proved to be effective in enabling her to think positively about herself and to change her behaviour (such as self-pity), as she uttered: “I have to do what I desire to do and do it well, and should not pity myself”. Role-play which involved forms of assertiveness and social skills training, gave her the necessary insight into handling her sister and others who were discriminating against her. The distancing and distraction method that she used to cope, namely to watch TV and DVDs, appeared to be effective as it enabled her to get some distance from the constant flow of maladaptive thinking.

The intervention model could be seen as effective in this case because it enabled the client to deal with suicidal ideations, low self-esteem, and fear of death, anger and depression mainly resulting from stigma and discrimination that was internalised. Therefore, the client had later on empowered others to cope with the disease suggesting that she was doing well. The psychometric assessments that were conducted post-therapy further confirmed the participant’s coping, as can be seen that she experienced less scores on depression (15 before which is considered mild mood disturbance to 1 afterwards which is regarded as normal ups and downs), less internalised stigma (44 before; 19 after), and higher self-esteem (8 before; 0 after) after having participated in eight therapy sessions.

Participant 10

Session 1

1. Context

The participant was a 36-year-old married woman who was HIV positive and had one child. She was seen at the Wellness Clinic and agreed when requested to participate in this research. She mentioned that she was the lastborn in her family and had many family-related problems since siblings were fighting each other. She pointed out that her husband was also HIV positive and that he smoked dagga and consumed alcohol excessively. His substance abuse could be attributed to him trying to escape everyday hardships. She stated that her husband was not very co-operative when coming to taking his ARV treatment. She indicated: “I am carrying a lot of problems. I am overwhelmed with their problems”.

She stated that she had only disclosed her status to her husband and mother. Her mother was mentioned as a person who gave her moral support. She seemed to have many regrets about the past. She felt she could have studied before contracting the virus. She reported: “I feel that I should have listened and gone to school. By now I could be working and happy but I did not listen. I feel bad that I have misused my time. I should have been having a proper job somewhere”.

She reported to have been emotionally affected since her diagnosis was made known to her: “I was deeply hurt. I have been sick since then ... I also have lots of stress that does not even come to an end”. She seemed to lack knowledge about her condition as she indicated: “my understanding of HIV is that I should never engage in sexual activity”. The disease has had an impact on her body image because she stated to have drastically lost weight. She indicated that she experienced severe stress about how to disclose to others and about how she would be perceived by people as a person living with HIV. Hence, she had so far disclosed her status only to her mother and husband. She stated that she coped by praying in most cases and appeared to be denying reality.

2. Definition of the relationship with the counsellor/researcher

She entered the relationship in a one down position by putting herself in the position of follower and the therapist as leader, and this was maintained throughout the entire therapy process. She seemed to be finding it difficult to hear properly as discussions often had to be repeated.

3. Distance (Punctuating from the participant’s point of view)

3.1 Acceptance of reflections

An appropriate distance was maintained by the client throughout the therapeutic relationship and she did that by accepting reflections of feelings.

3.2 How did she express herself?

She spoke about her diagnosis in a transparent and congruent way by volunteering to give details about her HIV condition. She presented herself in a defeated and helpless manner. She blamed herself for living with the virus and worried about how others would react when they come to know about her status.

3.3 Manoeuvres and behavioural patterns

A pattern of closeness was maintained throughout the relationship, which was noticed when she accepted reflections of feelings. She manoeuvred for support and understanding when she gave details about her disease and narrated them in a helpless and defeated way.

4. The client's support system

Her support system consisted of some of her siblings, mother, in-laws and her child. She indicated that she received moral support from her mother, who seemed to understand her. Her husband, in-laws and other siblings did not offer her the necessary support. Her in-laws were said to be blaming her for the husband's ill health and they did not know that both husband and wife were HIV positive.

5. Hypothesis

Given the bad treatment she was receiving from the in-laws, the husband's lack of cooperativeness regarding treatment and the fear of stigma she was experiencing, she felt depressed, regretful and tended to blame herself following her diagnosis. It could also be hypothesised that she associated HIV/AIDS with witchcraft, spirits or supernatural forces (Aggleton & Chase, 2001), hence her hesitation to disclose to the in-laws. She feared that they would think she was bewitching him. Her interactional style tended to have the effect of distancing her from others because she feared she might be discriminated against by people as soon as they learnt about her diagnosis. Thus she tried to cope by not disclosing her status. In this way she was probably depriving herself of the possible support she could be receiving.

6. Symptoms

Given people's negative perception about HIV/AIDS, her feelings of depression, low self-esteem and regret are as a result of the internalised stigma.

7. Goals of therapy

The aim of CBT that was presented was to assist her to deal with the cognitive distortions she was experiencing in order to help her function satisfactorily in her environment.

8. Type(s) of intervention used and the reaction of the client

She presented with feelings of regret about her past as she pointed out that she had misused her time and that she should have listened and gone to school. Positive cognitive reframing was trained to help her consider alternative interpretations of her diagnosis. For example: "...now that you live with this disease, it would be better to focus on something constructive you can do instead of regretting about the past and things you could have achieved". She did not engage with the suggested ideas, therefore it was difficult to know if she understood or not. Her homework assignment was to reflect on what could be done to make her situation better rather than to regret about the past and the fact that she could have studied before contracting the virus.

Reflections/Comments: Not much progress could be attributed to the positive cognitive reframing that was taught. It was actually ineffective, because she only responded by saying: “okay”. She was not yet common with this technique as it was new and she could possibly not incorporate it into her lifestyle. The technique could have also been given enough time for her to grasp it.

Session 2

The participant’s feelings of powerlessness, which included loss of confidence and self-worth due to the in-laws blaming her for not taking proper care of her husband and her internalising it, were dealt with in this session. Her previously assigned homework assignment was discussed and she reported to slightly remember it. Having been reminded, she could not dwell on it and rather focused her attention on something different as she said that she does not know what could be suggested to keep her busy. She needed to know what to read so as to cope better with this disease.

Some coping strategies were taught in order to assist her to cope with her disease. For example, she was encouraged to read magazines and articles about this disease, as they would enlighten her about other people’s experiences and how they live and cope in a positive way. That would also help to be aware that there are many people who live with the virus. It was further suggested that she listens to television when they talk about HIV/AIDS so as to gain better knowledge. She stated that her husband does not listen to meaningful programmes on TV, especially about HIV/AIDS; as such they quarrel over who prefers which programme and she does not have another TV.

Positive cognitive reframing of her negative automatic thoughts was taught with the aim of helping her to think of other ways of handling the situation she was faced with. Therapist remarked that her husband might still be finding it difficult to come to terms with this disease. Hence, he was avoiding anything that has to do with it. He was mentioned to have misused all his money, thinking that he will die soon. He also throws away his tablets in the bin or in the dam as he is required to have a certain limited number when he comes to the clinic so that they are convinced that he is drinking his treatment regularly.

Some problem-solving skills were taught in order to assist her to handle the problems of her husband: “... he would require psychological help, as there might be some relief in terms of stress in the house if he happens to come to terms with his condition”. She answered: “maybe I can live a better life if he would accept his condition, because he stresses me a lot. People even ask why he is a disgrace and see him as a sick person and me as being better – as such; they might think that I am not helping him at all”.

Her negative thoughts about her not helping him were reframed when the researcher endeavoured to help her think positively about it. For example, she was encouraged to go on with her positive attitude in life and not see herself as not taking proper care of him as others see it. The woman was shown that it was indeed his choice to decide what type of life he wanted to live, as it is him who possibly wanted to die soon. She was furthermore advised to change the way she looked at it. Her reply was: “my husband is worse in terms of his misbehaviour”. He was stated to be taking out a drip on his own if hospitalised and also leaves a spoon carelessly after eating, and her worry was about her child who would get infected from such a spoon. It was clear that she was greatly worried about her husband’s inappropriate behaviour.

The woman was given insight by being educated about ways of HIV transmission in order to enable her to allay her fears about her child acquiring the disease. She responded: “okay! I just wanted to know about that”. Her homework assignment was to further consider what was to be done about her in-laws who blamed her for not taking proper care of her husband even if she did. Their accusations seemed to be impacting negatively on her self-esteem.

Comments: She appeared to be hopeful due to the positive cognitive reframing she received, for example: “as you have advised me previously, I feel better today and have hope that one day God is going to help me like others. I need to start accepting myself first”. She was also hopeful about the problem-solving skills that were taught as she stated that she could be less stressed if her husband received help. Education about HIV transmission gave her insight about how the virus is contracted. She was battling to grasp some coping strategies which were taught, as she would react by talking about other things not related to the techniques. Her homework assignment also proved not to be effective as she had not done it and she talked about something different. The reason could be that she found the homework to be difficult. Her low level of education contributed to lack of understanding as she had passed only grade ten. Given her low level of functioning it could also be hypothesised that her ill health related to HIV/AIDS was affecting her because she would at times give irrelevant answers.

Session 3

Her feelings of guilt about her past behaviour, regrets and negative self-evaluation regarding the in-laws were addressed in this session. Her homework assignment was also explored and she mentioned: “I still continue to love him as I used to and offer him support where necessary. I have accepted that God knows that I am really taking care of him and that I do not have control over his life and behaviour. So I am not scared of anything, as I can tell them (*the in-laws*) and he can also talk on his own about whatever he does and they will end up agreeing with me”.

She was taught positive cognitive reframing to help her think of her difficulties in a different way. The researcher reported that some family members would possibly realise her efforts and care and not all the people will see her in that way. She was encouraged to go on with her life and continue to offer help as she used to. That was possibly an attitude that she could adopt, instead of feeling guilty, regretting and evaluating herself in a negative way when she should not. The researcher remarked: “you have a choice of looking at it in this way – you do not have control over his life, but you have control over your own life”. She answered: “yes, it is like that as I cannot satisfy all the people because he does not drink his medication. He is also taking traditional medicine and he neglects the Western treatment”.

Socratic questioning and reality testing was taught about her self-blame to assist to change her perceptions of the in-laws: “you know that you are doing a lot for him and how come that you should continue to unnecessarily blame yourself when you are not supposed to”. She did not engage with the suggested ideas, therefore it was difficult for the therapist to know if she understood or not. Decatastrophising was taught to assist in preparing her for the worst with regard to people’s remarks. For example, she was warned that people are going to continue to talk and she still had to decide how to deal with such talk. Expecting the worst in dealing with people was suggested. She commented that her husband had not disclosed to anyone including his family, as such, they did not know what he suffered from. Her assignment for that week was to write good things about herself. This was aimed at helping her to cope better when faced with difficulties.

Comments: She seemed to be doing well in the homework assignment as it proved to be effective with regard to coping with the negative comments regarding neglecting her husband. She said: “... I am really taking care of him and I do not have control over his life and behaviour ... I can only help a person who helps himself”. Based on her statements, the participant showed in this session that she was familiar with the homework assignment techniques and finding it easier to implement the related skills. Positive cognitive reframing also seemed to be effective, as it changed her perception about the in-laws and indicated that she cannot satisfy all the people because her partner was not prepared to drink his medication. Socratic questioning and reality testing proved not to be effective yet, as she only answered by merely saying: “yes”. Decatastrophising did not work well since she gave irrelevant answers. The other reason could be that the techniques were presented together with other therapeutic skills and she was possibly still unknown with these strategies given her level of functioning. The researcher also felt that it was difficult to engage this woman in therapy and keep her focused on the topic under discussion.

Session 4

The implications of the participant's behaviour such as self-pity and self-isolation that were related to HIV/AIDS were discussed. Her assignment to write good things about herself was also discussed and she reacted: "what I need to do in life is to accept my current situation of living with the virus. The second point is that my friends and relatives will no longer love me as they used to. Thirdly, I need to follow all the rules as a person who lives with this disease. Fourthly, I will ask God daily to live longer". It was evident in this instance that the participant did not understand the positive self-statement logs homework, as she did the wrong task. The researcher reminded her of the assigned task and she replied: "it means that I have done things the other way round as I am not well in my mind because of this sickness. I have forgotten to do the right task". It could be noticed that the participant was experiencing memory and concentration loss, possibly as a result of HIV/AIDS.

Now that she was reminded of her homework assignment she said that she is good in public speaking and was not ashamed of explaining to others about HIV/AIDS since she received therapy that gave her courage. She further indicated that it was better in a place where she was not known. Some coping strategies were presented to empower her to cope with HIV, when it was mentioned that talking about this disease helps to cope in a better way, and she would learn more about the disease and that may bring joy in her life as she enlightened others about what they did not know. Further coping strategies were taught that talking about the disease will possibly not see her mind wandering on about issues like neglecting herself, suicide, self-pity and self-isolation. Her answer was: "I agree with you".

Decatastrophising was presented to assist in preparing her to deal with discrimination regarding people's negative remarks. For example, it was pointed out that she could be discriminated against by other people whom she would be going to disclose to. As such, it would help to be prepared for the worst by waiting for the worst as she would be going to engage in this exercise. Her homework assignment was to reflect on where and when she would like to start educating others about HIV/AIDS and to again list good things about herself.

Comments: She showed to be willing and hopeful to tell others about her status and that could be attributed to good progress due to the coping strategies she received. The participant was starting to incorporate decatastrophising techniques into her thinking, and these proved to be effective, as she said that she needed to accept living with the virus and that her friends and relatives will no longer love her as they used to. In this instance, she was referring to the time when she would be disclosing her status and would possibly expect anything from people. It can be noticed that decatastrophising technique brought the change process in the manner in which she regarded her diagnosis. Her

homework assignment that was given in the form of positive self-statement logs proved not to be effective as she did not do the relevant task.

Session 5

The client's experience of the reaction of others was dealt with, given the fact that she was prepared to disclose her status to others but wondered what they would think of her living with the virus. Regarding her homework assignment she uttered: "I am HIV (*positive*) and I no longer care how other people talk about me. So those are the good things about me". She further mentioned that she can start to disclose at a place like Kriel because she was not known there.

Therapist suggested that she consider advantages and disadvantages, which is a method of modifying negative automatic thoughts to assist her to get things in perspective. For example, she was shown that a place such as Kriel could be far for her since she goes there as a volunteer and there are other issues of transport fees that are involved. She was assisted to think of the advantages and disadvantages of a place that is closer by such as the clinic next to her, where she could be walking to it instead of spending money on transport to a place far from her. Her response was: "what if they talk bad about me".

She was taught about anti-discriminatory laws in order to be equipped, as she would be faced with stigma now that she would be talking to others about her status. She was taught that anti-discriminatory laws protect her from being discriminated against by people and she can report at the police station if there are people who discriminate against her. Decatastrophising was taught to assist in handling difficulties she could be faced with. For example, she was told that if she preferred to disclose her status in an unfamiliar place, she might still have people who know her and would tell others where she stays about her status. As a result, she needed to be prepared for the worst as she had any way decided to disclose publicly and help other people cope and adjust to living with the disease as well as deal with internalised stigma and the discrimination that they experienced. She appeared to be agreeing with this line of thought.

Assertiveness and social skills training was taught in the form of role-play to equip her to be assertive in her interactions with others, when the researcher said: "be ready for their bad comments and to assert yourself in such circumstances where you should be talking to them in a polite and assertive way. If confronted about the disease you will politely say: 'It is of course true that I am living with the virus. I was tested and I am of course better off knowing that I know my status. It helps me to take my treatment regularly so as to have a prolonged life span.' Can you do that?" She said: "okay".

Positive cognitive reframing focused on how to deal with discrimination. For instance, she was taught that she needs to start accepting herself in terms of being aware that she cannot change her status and have a way of knowing how

to handle people's comments. She responded: "I can hear you and I now understand that I do not have to fight other people when they are rude and discriminate against me. I should deal with it by telling myself that I live with the virus and I cannot change my status. However, I am better because I am on tablets that I receive". She questioned about what to do if a person continues to talk. The researcher said: "in a nice and polite way you say what I have said and do not fight with such a person". The participant's task for that week was to practise being assertive.

Comments: The client seemed to be doing well in respect of the assertiveness and social skills training that was taught in the form of role-play, as she indicated that she understood that she did not have to fight people if they were rude towards her. The positive cognitive reframing strategy proved to be effective with regard to the discrimination she was faced with as she said that she would deal with it by telling herself that she lives with the virus and cannot change her status. The participant appeared to be positive in terms of thinking and coping at this stage, and that facilitated the process of change. Her homework assignment proved not to be effective as she did not do it and had to be reminded of it during therapy. Listing the advantages and disadvantages of a situation or choice, this is a method of modifying negative automatic thoughts proved not to be effective, possibly because she needed time to think about this technique. That was not the case as she did not do her assigned tasks. Being taught about anti-discriminatory laws as well as decatastrophising also proved not to be effective too, as she only replied by saying: "yes". Another reason that prevented her from grasping these techniques was probably that the researcher focused more on cognitive level instead of engaging her on behavioural strategies that would have made a difference in changing her thinking and behaviour.

Session 6

Her feelings of uncertainty about the future were the focus point of discussions in this session, together with issues arising on that day. The participant's assignment was explored and she stated: "I do try to assert myself in my environment by talking politely to my in-laws". She further said that her in-laws would not even bother by phoning to find out about her partner's progress. She stated: "I tell them all the time when he is sick and I say it once and repeat it in the same manner as you taught me and I tell myself that God will see me through". It could be seen that she had started to assert herself in her environment and her believe in God was offering her courage.

Positive cognitive reframing was further taught to assist her to think positively about her situation with her husband. She was for instance reminded that she can only help him if he required her assistance. She was once more taught to learn to think about this situation in a positive way instead of viewing herself in a negative way as if she was not helping him at all. Her response was irrelevant as

she stated that the in-laws only come when he is seriously ill and she has to spend money for them coming.

A few coping strategies were taught to assist her to deal with her worries about the in-laws and the husband. The therapist indicated that she needs to have a way of managing her stress by not feeling responsible for his deeds or feel guilty. The woman was shown that her partner has a chance of taking his medication, eating a balanced diet and leaving the drugs he is abusing. However, he preferred to live his own life and she has to live her life to the fullest now because she made the right decisions about it. She was further notified that her husband was going to be worse if he did not change. She said: “he is of course worse and many people can see that”.

She was furthermore taught coping strategies: “one cannot push him to do right things if he does not want to do so. He deserves psychological treatment if he is willing to be helped”. She stated that he did not come last time when she arranged such a meeting with one of the psychologists. The researcher added that her husband was in denial and not even seeing help that is given to him. She answered: “I am now feeling better and I take things as they come, especially when I deal with him. My mother is also encouraging me, showing me that most people see him as being irresponsible and I have learnt to accept that too”. For the next session she was tasked to reflect on her future plans over the next five to ten years. That was done to assist her to focus on the future instead of spending time thinking negatively about herself.

Comments: She was improving in terms of dealing with her partner and as a result of the coping strategies that proved to be effective, because she pointed out that she had learnt to take things as they come. Her homework assignment proved to be effective as she had started to apply the assertiveness technique outside therapy session in her dealings with her husband and the in-laws. Positive cognitive reframing however showed not to be effective, since her responses were irrelevant.

Session 7

Her tasks to reflect on her plans for the next five to ten years were explored in this session and she stated that she wants to live and accomplish her goals by taking care of herself. She wanted to obtain employment and live a normal life and not end up feeling guilty about herself. She wanted to join AIDS campaigns such as the Treatment Action Campaign to teach others to take care of themselves too. She came to recognise that the fact that she lives with the disease does not mean that she was no longer a person, as she was still similar to others and needed to respect herself as usual. One could notice that she was thinking positively about her diagnosis at this stage.

This session was dedicated to teaching the participant about the coping strategies such as seeing other people as role models to assist her to cope. She was also reminded that setbacks are normal and she may not be happy at all times. As a result, she was informed that on some days she might feel sad when she thinks of this disease but that should not make her think that she is not coping. Reading some of the brochures that the therapist gave her was encouraged to assist her to acquire knowledge about this disease.

Decatastrophising was again taught to prepare her to handle difficulties she could come across. The therapist indicated that she should tell herself that anything is possible in dealing with people as they may be speaking in a negative way and discriminating against her. She was told that she needs to be ready to handle such day-to-day issues. That helps her to build a more effective and functional way for responding to internalised stigma and discrimination. Her homework for the last session was to imagine future difficulties and how to handle them.

Comments: Her homework assignment proved to be effective in facilitating positive change and the client was at ease with this strategy, as she seemed to be determined to accomplish her goals by talking to others about the disease. She seemed to be doing well on the coping strategies she received. They proved to be effective in changing her stigmatising thoughts about HIV/AIDS, because she regarded herself to be still similar to others. Not much could be said about the effectiveness of decatastrophising techniques as she responded by saying: “yes”.

Session 8

The participant’s homework task was discussed and she stated: “my husband is still sick and the worst thing that could happen to him is that he could die, which is the homework that I had to think about for today seeing that he is still hospitalised”. She reported that it was not going to be easy for her because she would be facing the in-laws with their bad comments and non-caring attitude. She added that she does comfort herself by saying that the life of a person is not in her hands as it is in God’s hands. So even if his family can blame her for his death, thinking that she bewitched him that is not the case. So, if he died, she was prepared for any bad comments, as therapy had at least equipped her to cope with them. One could also notice that her faith in God gave her courage and enabled her to cope.

Coping strategies were recapped in this last session. The researcher encouraged her to disclose her status to the in-laws. That way they could learn from her that he was living with the disease and that he was not complying with his treatment regimen, which possibly made his situation to be worse. For example, he remarked: “by disclosing your status you would be showing them that it is possible for a person to live longer with the virus, as long as one is thinking

positively, adhering to the treatment regimen, eating a balanced diet and practising safe sex. Talking about HIV/AIDS would mean that you are de-stigmatising the disease and you would be encouraging others to undergo testing in order to know about their status". She reacted: "... you have helped me to become a better person because I can see light at the end of the tunnel and I am now able to cope well".

The participant was educated once more on decatastrophising to further help prepare her for the worst. For instance: "being prepared for the worst would help you to deal with the internalised stigma and discrimination that you might come across". In instances such as these ones that she talked about, she was made to realise that she would have done all she could to assist her husband to cope and live longer, as she also referred him to professionals but he did not honour the appointments. So expecting any other negative comment from her in-laws in case he happens to pass on would help her to cope.

Comments: Coping strategies taught to the client worked well in influencing her to think of herself positively because she seemed to be determined to face the world. Her homework assignment that was given in the form of a decatastrophising technique was effective in assisting her to imagine the worst that could happen to her and how to resolve that, as she indicated that she was ready to phase and deal with her in-laws should they blame her for any other thing that could happen to her partner. Based on what she said, it could be seen that she was at ease with these strategies and could implement them.

Overall discussion of participant 10

To summarise, it is evident that a technique that did not prove to be effective was the positive self-statement logs as she did not do the relevant task she was assigned to practise. Socratic questioning and reality testing did not work well either, since she answered by nodding her head and the researcher did not know if there was a change in thought process or not. Listing of advantages and disadvantages, which is a method of modifying negative automatic thoughts, did not prove to be effective - this possibly failed because she needed time to think about this technique and that was not the case, as she did not complete most of her assigned tasks. This made it difficult for her to grasp the skill. The reason for the failure of these techniques could have been that the researcher could have engaged her more on behavioural strategies instead of focusing mainly on cognitive skills. The researcher also felt that he was losing her as she would at times give responses that were not related to what was discussed.

However, the strategies that proved to be effective were coping strategies that changed her way of dealing with HIV/AIDS, as she regarded herself to be similar to others and was telling them about the disease. Problem-solving skills seemed to be effective as it changed her attitude towards others since she came to realise that she cannot satisfy all the people because of what they say about her,

especially the in-laws. Positive cognitive reframing proved to be effective in changing the participant's negative perception about the disease and her regrets about past behaviour. Although she did not do some of her homework assignments, the ones she did proved to be effective in facilitating positive change because she started thinking positively about herself: "... I want to live and accomplish my goals by taking care of myself and educate others about the disease".

The education she received about HIV transmission also proved to be effective as she gained insight about how the virus could be contracted. Modification of negative automatic thoughts by means of the method of decatastrophising was effective in empowering her to think of the worst that could happen to her and how to resolve that, such as imagining her husband's death. Assertiveness and social skills training that were taught in the form of role-play proved to be effective with regard to asserting herself and managing the in-laws and to deal with the discrimination she was faced with.

Although the researcher felt as if he was losing her at some stage, she seemed to be coping given the fact that therapy enabled her to deal with people's negative perception about HIV/AIDS, her feelings of depression; low self-esteem and regret as they were as a result of the internalised stigma. The quantitative instruments that were administered post-therapy confirmed the qualitative results and corroborated the effectiveness of the intervention model as it can be seen that the woman experienced less scores on depression (25 before which is moderate depression to 10 afterwards which is considered in the normal range), less internalised stigma (46 before; 22 after), her self-esteem scores (10 before; 2 after) improved significantly as well as positive coping scores (27 before; 38 after) after having participated in eight therapy sessions.

The following section will provide an analysis of the use of each technique and how the participants responded to the different skills.

5.4 THE VALUE OF EACH THERAPEUTIC TECHNIQUE USED

The researcher will provide a summary of the value of each cognitive and behavioural technique used in therapy with clients. The definition of each skill and how it was implemented was already discussed in Chapter 3 and 4. The table below will be used as a guideline for the discussion in this section.

Table 5.3: Summary of the value of various cognitive behavioural therapy techniques

Techniques	Number of clients the technique was administered to:	Techniques effective with the following client(s):	Techniques not effective with the following client(s):
Positive cognitive reframing	10	All ten (10)	-
Teaching coping strategies	10	All ten (10)	-
Homework assignments	10	All ten (10)	-
Problem-solving skills	7	1, 3, 5, 6, 8 & 10	7
Decatastrophising	10	All ten (10)	-
Advantages and disadvantages	3	5, 7 & 10	-
Identifying, challenging and changing underlying negative automatic thoughts and assumptions	9	1, 2, 3, 6, 7 & 9	4, 5 & 8
Education about HIV/AIDS	5	2, 4 & 10	6 & 8
Positive self-statement logs	3	3	4 & 10
Socratic questioning and reality testing	7	2 & 7	3, 5, 8, 9 & 10
Assertiveness training	10	1, 4, 5, 6, 7, 8, 9 & 10	2 & 3
Role-play	7	5, 7, 8, 9 & 10	2 & 3
Graded task assignments	2	1	7

5.4.1 Cognitive techniques

The women and the therapist were co-investigators in endeavouring to uncover the underlying thought patterns, interpretations and evaluations that might have contributed to the women's negative experiences of HIV-related stigma. The researcher's evaluation of some of the cognitive techniques is explained below.

Positive cognitive reframing: This technique was used to provide clients with positive alternative interpretations of HIV such as: "HIV could be contracted by any other person and should not be viewed as a punishment of bad behaviour". This strategy was effective in assisting all the women to think positively despite hardships and the stigma they were experiencing from others. It must be conceded that it was hard to think positively when one was going through tough times. Client 9 said: "I would like to carry my friend, which is my treatment, in my bag all the time – even if I go on holiday". It could be seen that her relationship with HIV had changed.

At first this technique was probably difficult to understand, given the fact that HIV/AIDS is often associated with death, moral judgement and a failure to follow cultural traditions as identified in African communities. However, after a while, women started to come up with more constructive alternative ways of thinking about their disease, which was effective. Client 3 said: “I have to take care of myself like I used to before I was diagnosed with this disease instead of worrying about death as all of us are going to die anyway”. It could be noticed that she had gained insight about how to look at her diagnosis in a different way.

Teaching coping strategies: Given stigmatising connotations, the focus of coping strategies was on encouraging women to utilise the time they were left with (since HIV diagnosis) effectively to accomplish their goals by assisting others to cope with the disease, listen to music, joining support groups and praying. Women were informed that they are not the only ones living with HIV/AIDS and it should be regarded as a chronic disease they can live with. They were further told that if people stigmatise them, it does not change them as they are still the same people. For example, the researcher stated: “I would encourage you to help others by being involved in HIV/AIDS-related tasks - by doing so, you would be encouraging disclosure and raising risk awareness, hence empowering yourself to cope”. Coping strategies were taught to all the women and it was effective in enabling all of them to cope with the disease as client 1 said: “I am now free to talk to others about the disease unlike before I could come here for therapy”. It could be seen that she was no longer scared and afraid of HIV – hence she was able to empower others about the disease and was coping.

Homework assignments: The success of the women in therapy was facilitated by their completion of cognitive and behavioural homework assignments. Many of the women forgot to do their tasks and as a result this made it difficult for them to start thinking differently. Some of the women (clients 2 and 10) would be regularly admitted to hospital for ill health. As such it would be difficult for them to think of the assigned tasks, given their state of health. Client 6 focused on burying loved ones and as such she would not remember her homework tasks. A few of the homework assignments (like practising assertiveness training and thinking how self-pity and self-isolation would assist to cope) seemed to be difficult for them given their level of intelligence. However, the tasks that were completed successfully proved to be effective in helping them change their negative perception of the disease to start thinking constructively. For example, for some women (clients 1, 2, 3, 5, 6, 7 and 9) who were suicidal, being tasked to find a reason for living gave insight into the fact that there were still children to be brought up and or family members and others to be taken care of, instead of ruminating on negative automatic thoughts.

Problem-solving skills: Clients were helped to solve some of their daily problems. For example, client 3 did not know what to do with her son who was performing poorly at school and considered suicide to escape the situation. The

researcher suggested psychological evaluation and taught the woman assertiveness skills to talk to the teachers about her son. It was noted that the knowledge acquired brought some relief with regard to knowing what to do with her difficulties. Problem-solving skills were taught to clients 1, 3, 5, 6, 7, 8 and 10, with some success. It was not effective with client 7, possibly because she was preoccupied with lack of support from family and fear of stigma and discrimination she was faced with.

Modifying negative automatic thoughts: A number of methods were used by the researcher to help women modify their negative thinking, such as the following:

Decatastrophising: All ten women were asked what would be the worst thing that could happen if others knew about their HIV status. That was done to prepare them for the worst in dealing with the stigma they were experiencing. The other rationale was to make them aware of the fact that when fear is confronted, it often becomes clear that it is not so terrible after all. For example, the researcher said: “be prepared for the worst so that if that happens, you should be ready for it. People will not stop talking when you disclose more about your status. Make room in your thoughts or be prepared for that, so that if others are offensive and discriminate against you, you will have been ready by expecting such comments”. The technique proved to be effective with all ten women as they showed to have gained insight in anticipating the worst in dealing with stigma and discrimination they were faced with. Client 9 commented: “people are of course going to talk especially when you live with this disease - so I am ready for such talk”.

It took some time for women to understand this technique and to start thinking of or visualising future difficulties and how to handle them. The technique therefore had to be presented on a few occasions. The women’s level of intelligence also played a significant role in delaying them to understand this strategy. Perceptions of stigma within the South African community probably also contributed to the women’s fears, given their exposure to discriminatory behaviours in their community and to media reports that emphasised discriminatory practises (Atlenroxel, 2000; Streek, 2001) and controversial issues surrounding HIV.

Advantages and disadvantages: If a difficult decision was to be made or if it seemed difficult to give up a particular maladaptive behaviour, women were encouraged to list the advantages and disadvantages of a certain course of action. For instance, the researcher pointed out the advantages and disadvantages to client 7 who was undecided about assisting her father at his shops – as her father needed her and that was not the case with his employees. The strategy was taught with an aim of assisting her to decide what to do.

Not much could be said about this method for the other three women (clients 5, 7 and 10) because it could be that women followed the process and this could

have contributed to different thinking, but the researcher doubted if they would be able to do these themselves after therapy. However the evaluation of this technique was based on that session alone in which it was administered. It was however noted later during the process of therapy that all three women learnt the technique as it changed their thought processes. For example, client 5 later indicated that she considered the advantages and disadvantages of disclosing her status to her boyfriend, of which she ultimately told him. She then received support from him that she did not expect because she feared being left by him.

Identifying, challenging and changing underlying negative automatic thoughts and assumptions: It was difficult for most women to identify their negative automatic thoughts and to challenge the rules that guided their maladaptive behaviour. This worked in cases where the therapist contributed to the identification of thought patterns. For example, in all cases, the researcher tasked the women at the end of a therapy session to monitor negative thoughts and beliefs that crossed their minds by observing, recording and changing such negative automatic thoughts such as suicidal ideations that would occur now that they are HIV positive. For example, client 3 said: “it is slightly difficult for me”. She explained that she wanted to commit suicide because of her son’s problems at school. She further stated: “when I have to face all this, I experience all these negative thoughts”. The researcher could then identify the negative thoughts and challenge them: “how come that you want to kill yourself if your son is not coping at school because that has nothing to do with you being HIV positive?”

The women were shown that such thoughts coming to mind automatically were often distorted or unrealistic and challenged them to consider their validity. Women were then given the homework task of collecting and recording these negative automatic thoughts. These techniques were administered with nine clients (1, 2, 3, 4, 5, 6, 7, 8 and 9) and they proved to be effective with six clients (1, 2, 3, 6, 7 and 9). Identifying and challenging thoughts was a therapeutic exercise, as it gave women the insight that their inappropriate behaviour (such as self-isolation) was the result of their negative thinking (for example, they were bad because of their diagnosis). The strategies did not prove to be effective with clients 4, 5 and 8, as they did not understand the way of thinking. It may take more time to learn self-reflective skills and to learn different thought patterns.

Education about HIV/AIDS: The information women received from the researcher especially about HIV transmission was aimed at giving them a clearer insight into their disease in order to facilitate understanding of their diagnosis. Clients 2, 4, 6, 8 and 10 were taught about signs and symptoms of HIV/AIDS and its transmission. The knowledge gained about their condition contributed to the women’s ability to deal with this disease differently – as this information was effective with clients 2, 4 and 10. For example, client 4 mentioned: “I am learning a lot because that is how I started to realise that I have this disease. I will go and talk to others informing them that they need to urgently seek professional help if such signs develop”. Not much could be said about clients 6 and 8 as they were

just unresponsive. Client 8 was often preoccupied and overwhelmed by the abusive partner whilst client 6 was preoccupied with burying family members on monthly basis due to HIV/AIDS.

Positive self-statement logs: The rationale for this technique was explained to participants that whenever they experienced a negative thought about themselves such as thinking that they are useless following their diagnosis, they should consider the list of positive things about themselves. For example, they are still worth a living because they have children to bring up. This technique was administered with clients 3, 4 and 10 and it proved to be effective with client 3 as she responded: “the good things about me are that I have children and I think they need me and I also love them, and I need to take care of them”. It seemed as if the technique had assisted her to uncover positive aspects about herself, instead of thinking about suicide. However, this skill was not effective with clients 4 and 10, as it was presented only once in session 4 for both clients and it could have been repeated in other sessions to make it to be more effective. The other reason for its failure was that it was difficult for the therapist to engage client 10 in therapy and she did not understand this technique. Given the fact that women were also exposed to people dying because of the disease, it became tough to compile a list of good things about oneself under such circumstances.

Socratic questioning and reality testing: This technique was used as a series of questions to identify underlying thought patterns or assumptions or conclusions. This process was aimed at shaping the women’s thinking through active questioning and selective reflecting. This method was taught to some women (clients 2, 3, 5, 7, 8, 9, and 10) to help question the evidence for the automatic thoughts. For instance, women’s thinking that they were worthless now that they were HIV positive was questioned. It was hard for some clients (3, 5, 8, 9 and 10) to grasp these statements: “HIV/AIDS does not make you feel worthless and powerless as you can still live with it”. The reason for the failure of these statements could be that women could react to a challenge but that they will not be able to do self-challenge and this could have contributed to different thinking, but the researcher doubt if they would be able to do these themselves after therapy. So, they possibly benefited by the experience but did not learn the skill as an empowering tool. On the other hand, the researcher wanted the women to actively participate in questioning their assumptions, which never worked. In order to be effective, the technique should perhaps have been presented in other sessions. In the long term this may have been effective, because the women were enabled to start looking at things from another angle and not only listen to what the researcher had to say.

However, clients 2 and 7 benefited from the message and it worked well for them, as client 7 remarked: “I do not have to feel worthless about myself now that I live with this disease but I must face the world and deal with the fact that my father discriminates against me whilst other people show love towards me”.

5.4.2 Behavioural techniques

Some behavioural techniques that were used are evaluated below:

Assertiveness training: This was a cognitive change technique utilised for women as they had social problems that needed to be solved. Behavioural techniques based on a skills training model were especially useful. This involved forms of assertiveness training or social skills training for women who lacked interpersonal skills. Assertiveness training was demonstrated to all ten women to help them assert themselves in their interaction with others as they were talking about their disease to raise risk awareness. For example: “by being assertive it means that you believe in yourself”. Assertiveness training proved not to be effective for clients 2 and 3 only – with client 2, it was difficult to involve her in therapy and with client 3, she replied by nodding her head and said: “yes” and was preoccupied with fear of discrimination and her son being a victim of discrimination at school. The rest of the women (1, 4, 5, 6, 7, 8, 9 and 10) benefited from the skill as client 9 stated: “you indicated last time that if a person is talking to me I should not argue with such a person. I have followed your suggestion because if I argue with him/her we will end up fighting each other – as such I should remain calm and just assert myself”.

Role-play: Role-playing was used to attempt to uncover automatic thoughts, to develop a rational response and to modify intermediate and core beliefs. In this respect, clients 2, 3, 5, 7, 8, 9, and 10 were taught assertiveness training in their interaction with others - through role-play. Assertiveness training was role-modelled to for instance, equip client 3 to address her fear of being stigmatised and to help her son who was the victim of discrimination at school. The researcher role-played the skill to the client and said: “can you try that with me?” This client (3) could not perform and practise the role as it takes time to develop it. It must be noted that it was initially not easy for women to understand this skill; as a result the researcher had to role-play this technique on several occasions to promote understanding. Clients 2 and 3 did not benefit from this skill, given the same reasons cited for them not grasping assertiveness training. The rest of the women (5, 7, 8, 9, and 10) benefited in being assertive through role-play. In this research, role-play was used to teach clients other skills as well.

Graded task assignments: The researcher, together with clients 1 and 7, began by setting small homework tasks, which gradually built up in complexity and difficulty. Women were encouraged to set goals that could realistically be achieved, so that they completed a series of successful assignments. Not much could be said about client 7 regarding the effectiveness of this strategy, as she did not do her assigned task. The other reason could be that the technique was not very effective as it was only taught once and it could have been repeated on a few occasions to help her find it suitable and use it. Another reason could be that she was experiencing ongoing problems such as being discriminated against by her family members. This made it difficult for her to focus on the graded task



assignments. Structuring behaviour that is, setting rules to prevent conflict was taught to client 1. The strategy was effective with client 1, as she remarked: “I am smiling ... because you are helping me a lot. I usually would be angry in dealing with such situations, especially with my children ... but I have learnt to handle the ongoing fights”.

In this chapter, a presentation of the results was discussed in detail. The next chapter will deal with the discussion of results and its implications in the light of existing literature and therapeutic approaches.

CHAPTER 6

DISCUSSION OF THE RESULTS

6.1 INTRODUCTION

The results provided in the previous chapter will now be discussed in Chapter 6. They include the identification of the problems that HIV-positive women experience and will be presented in the form of five commonly identified themes:

- Feelings of powerlessness
- Feelings of guilt
- Behavioural implications
- The experience of the reaction of others
- Uncertainty about the future

The above themes were addressed in the model for cognitive behavioural therapy that was developed to assist HIV-positive women in dealing with stigma. The development of an intervention that uses cognitive behavioural techniques to address the women's problems will be discussed. Critical evaluation of the intervention (both quantitatively and qualitatively) regarding the techniques that worked and those that did not prove to be effective will be discussed. Finally, conclusions will be drawn and recommendations for future implementation of the model will be discussed, as well as a critical evaluation of CBT as a therapeutic approach.

6.2 DISCUSSION OF WOMEN'S EXPERIENCES OF HIV AND AIDS-RELATED STIGMA

The goal of Phase 1 of this study was to gain an in-depth understanding of women's experiences of HIV and the internalised stigma related to HIV, and subsequently to develop an intervention model. The following methods were used to gain such understanding:

- A focus group discussion with three clinical psychologists
- The researcher's experience
- Available literature
- Five case studies of HIV-positive women

From the data obtained, themes were identified to be dealt with in therapy. Five psychometric instruments were used in the case studies to determine the level of depression experienced, self-esteem, internalised and enacted stigma, and types of coping strategies used. The themes identified in Phase 1 will be discussed

below, with examples included from the experiences of all the clients who were part of the study.

6.2.1 Feelings of Powerlessness

The women's feelings of powerlessness included loss of confidence and self-worth, as some of the participants in this study stated to be feeling worthless and ashamed of themselves soon after their HIV diagnosis. Their feelings of shame because they lived with HIV were confirmed by their scores on the internalised stigma scale. For example, client 8 said: "I feel ashamed and I have lost confidence in myself since I was told of this disease, and I no longer sing in church choirs". Women scored high on the Beck Depression Inventory; they often felt hopeless and helpless, and some wanted to end their lives or thought of the possibility of dying sooner. Depression may be a way of shutting down the emotional system so that it does not suffer a dangerous overload (Giddens & Giddens, 2000). Suicide is also seen as a way to escape inner pain and depression rather than working through difficulties (Giddens & Giddens, 2000). Client 3 specified that she had taken brake fluid upon being diagnosed because she knew that she was going to die soon and be discriminated against by others. These results corroborate with Orr's (2000) findings that when pronounced as HIV positive, many people feel completely hopeless because they believe that there are very few options left to them. Dharapak (2005) agrees that HIV-positive people feel as though their death certificates have been signed and that all that remains for them is to wait for death.

The stigma that is internalised (as illustrated in this research) attributes to lower self-esteem (confirmed by the women's scores on the Rosenberg Self-Esteem Scale (RSES)), self-doubt, depression and even premature death, because it discourages HIV-positive people to seek treatment (Santana & Dancy, 2000). Since HIV-positive people generally know how society stigmatises them or perceives them to be, they generally react by conforming to or resisting this view. Conforming involves internalisation of stigma or accepting society's negative judgement of one's identity as HIV positive. This is psychologically damaging because it reduces the self-esteem of the stigmatised person (Deacon et al., 2005). This fact was clearly confirmed in the current study. For example, client 2 said: "I no longer cook in family gatherings because people don't eat my food and that makes me to have low self-confidence". This low self-esteem in turn affected the way women responded to the illness, reducing the incentive to challenge stigmatisation or discrimination. Accepting the stigma and discrimination has undesirable consequences for the individual and public health programmes, since it reduces self-esteem and discourages being tested for HIV/AIDS, disclosure of status and the seeking of treatment (Deacon et al., 2005).

6.2.2 Guilt Feelings

Having received an HIV diagnosis, the participants went through different kinds of emotions. Classified as guilt feelings that women experienced, these included the following:

- Guilt feelings about past behaviour
- Anger that was directed inwardly in the form of self-destructiveness or suicidal behaviour
- Regrets
- Negative self-evaluation

People respond to stigma and other stressors in either positive or negative ways (Miller & Kaiser, 2001). The study also showed that the way HIV-positive women think about HIV-related stressors is an important factor that may account for individual variation in the ability to maintain a sense of subjective well-being in the face of a devastating fatal disease (Moneyham et al., 1996). It was also observed in this research that it was difficult for the women to accept the fact that they are living with the disease. For example, client 10 experienced guilt feelings and said: “I wish I could have listened when I was young because I would have not contracted the virus”. The participants’ guilt feelings were also confirmed by high scores (39, 40, 41 and 48) on the BDI-II scale.

Westbrooke and Viney (1982) mention that anger as a psychological reaction to the onset of chronic illness is often generated by feelings of frustration associated with the illness. Anger is a typical response to the unexpected loss of control over one’s life (Giddens & Giddens, 2000). According to Deacon et al. (2005) self-stigmatisation is a consequence of repressed anger as a result of being stigmatised. Feelings of anger generally dominated the responses the participants gave. This anger appeared to be mainly directed at the people who were thought to be responsible for infecting the women. Some of the anger was directed towards themselves and God, which is in line with the internalised stigma scale’s findings that contracting HIV is a punishment for bad behaviour. According to Kübler-Ross (1969), anger is displaced in all directions and projected onto the environment – at times almost randomly.

According to Mokhoka (2000), the difference in verbalising and admitting to these feelings of anger seems to be related to the type of relationship between the women and the person(s) who infected them. This corresponded with the findings of this research. The women stated that they were angry because their lives had been cut short and they were faced with the sudden challenge of having to adapt to a new way of living. Family members who were perceived as not being supportive of the women were also at the receiving end of anger, as client 5 said: “when I received the news about my HIV diagnosis, I got angry and I did not want to talk to any other person and I locked myself in the room most of the time”. Simos (1979) views anger as an integral part of the grieving process.

Related to anger, were feelings of hate and resentment, directed at people who were thought to have infected the participants. The emotional reactions furthermore included feelings of negative self-evaluation, self-blame (this was confirmed by the BDI-II and the negative coping stigma scales) and resentment for being infected by their spouses. Client 4 indicated that she had confronted her husband with a lot of anger after receiving her results because she trusted herself and related her being infected to his extra-marital affairs. This type of emotional response was quite common among the participants. Bennet (1990) refers to the common, yet often incorrect perception that if women are infected with HIV, they have to be promiscuous. Many of the women in this study considered themselves the victims of their spouses' infidelity.

Upon HIV diagnosis, women instantly thought of death which started a grieving process (Simos, 1979), often related to the loss of life associated with anticipation of death, or the loss of time, as a result of the now more limited life span. Client 10 indicated that she might have studied before her HIV diagnosis; she will no longer study because she will soon be dying of AIDS. This is similar to the findings of Hudson et al. (2001), namely that an HIV diagnosis is a serious life crisis dealing with issues of death and change in life expectancy, requiring considerable coping resources.

The worries and hurt experienced by Clients 6 and 7 were mainly related to the perception that they had troubled their neighbours and had become a burden to them. Most women's main worries were their children's well-being and their lack of a support system, given the fact that some of the women were being discriminated against even by their closer family members. This finding was also confirmed by the enacted stigma scale. The thought of bringing shame to their families and loved ones when people were to discover that they were HIV-positive also hurt and disturbed them. This is supported by the findings of Mokhoka (2000). Another chronic worry was about their health. Client 3 mentioned that she had witnessed her husband dying because of the disease and that she was worried that she was going to die like him. Client 10's feelings of worry originated from her husband who was also HIV positive but in denial. He appeared to be getting worse on a daily basis because of his lack of compliance to treatment and continued substance abuse. Lack of financial support played a crucial role in the women's worries because half of the participants (clients 1, 5, 6, 8 and 10) used the HIV grant they received to cater for their children's needs, and their personal and day-to-day needs at home.

6.2.3 Behavioural Implications

People's perception of HIV somehow influences the way HIV-infected people perceive themselves (Siegel et al., 1998). The women in this research feared and projected stigma and discrimination based on their own beliefs of what people might think of them and how people might act towards them. Women stated that their fear of HIV-related stigma from the community was based on lack of social support they received from the community.

Women in this study had experiences of self-pity, they felt isolated, neglected themselves and denied the fact that they were living with the virus. Their behaviour was also confirmed by the enacted stigma scale results, as some women indicated that their partners had left them because of their HIV-positive status. One of the participants indicated that she no longer went to the salon to have her hair styled, whilst most of them pointed out that they preferred to avoid social contact.

The types of treatment the women received from their families largely determined the way they related to their families thereafter. Their loss of interpersonal contact left women with feelings of isolation. Scambler and Hopkins (1986) also argue that internalised stigma often precedes, rather than results from, the enacted stigma. They claim that many individuals reduce the opportunities for enacted stigma in order to protect themselves from discriminatory actions. People living with HIV/AIDS therefore fear revealing their status and may withdraw from society because they expect that other people will reject them, irrespective of the enacted or real community stigma (Deacon et al., 2005). This is in agreement with the enacted stigma scale results, as some women indicated that people act as though it was their own fault that they were HIV positive.

The women's tendency to withdraw from society, which had an effect on intimate relationships, is also supported by studies on internalised stigma conducted by Santana and Dancy (2000), which showed similar findings.

6.2.4 The Experience of the Reaction of Others

This theme includes the women's response to HIV and HIV-related stigma. Most participants in this research disclosed their status selectively to only a few people for different reasons, especially fear of HIV/AIDS-related stigma. Their fears were based on how people had always spoken about HIV-positive persons and their negative perceptions of HIV/AIDS. The internalised stigma scale findings showed that women would understand if people rejected their friendship because they were HIV positive. When a person is diagnosed with HIV, she/he expects people to react negatively and much of the stigma becomes internalised. Because the women expected to be stigmatised, they did not disclose their status. Some of the reactions that the women had from people after disclosure or in response to HIV, further reinforced these feelings.

Siyam'kela's (2004) definition of stigma, namely that stigma is a powerful and discrediting social label that radically changes the way individuals view themselves and are viewed as persons, seems to be in line with the women's experiences of HIV and HIV-related stigma. The women felt as if they were useless and not worthy of living, and that their situation would be worse when others found out about their status. Such findings concur with the findings of Lie and Biswalo (1994), who mention that people are actually more fearful of the social consequences of AIDS than of the disease itself. An HIV/AIDS epidemic has from the beginning been accompanied by an epidemic of fear, ignorance,

blame, isolation, uncertainty, misperception and denial (Awusabo-Asare, 2000; ICRW, 2000a; LeBlanc et al., 2000; Whelan, 2002). This results in stigmatisation of and discrimination against people living with HIV/AIDS and their family members (De Bruyn, 1999; Wardlaw, 2000).

Findings of this research reveal that the women appeared to be worried about their physical appearance. They attempted to maintain weight in an endeavour to deflect attention away from their physical appearance and quell suspicions about their HIV status. Some of the participants, for example client 9, stated that she lied about her loss of weight when people asked by saying that she was on a specific dieting programme. The fact that the women worry about how they look physically seems to agree with Mokhoka's (2000) observation.

Miller and Major (2002) support the notion that stigmatised individuals, as was the case with women in this research, develop skills to compensate for stigma. These skills assist them to achieve their goals and overcome the disadvantages associated with stigma. One compensation strategy that they adopted was to try harder, to be more persistent and to pay closer attention to how they present themselves.

Responses to HIV cannot be categorised as adaptive or maladaptive; it depends on many factors in a situation. Although avoidance-coping mechanisms can be thought of as maladaptive, people living with HIV can benefit from some forms of avoidance-coping such as non-disclosure and rejection of negative ideas about their HIV status (Stein, 1996). These coping mechanisms do not necessarily contribute to denial of their status, but endeavour to reject its stigmatising connotations. Following the same argument, non-disclosure may be functional to the HIV-positive person's privacy and peace of mind, though it may also be seen as a maladaptive response of avoidance to accept their status. Women in this study nevertheless used this negative way of coping, which was shown on the negative coping scale. In the absence of safer sex practises, non-disclosure to sexual partners could well put them at greater risk of again contracting the virus.

One of the common perceptions by men seem to be that if a woman first tests HIV positive, she must have contracted the virus from elsewhere (Paterson, 1996). This is in agreement with Abdool Karim (2005), who states that cultural norms such as the community's acceptance of polygamy, which encourages males to have multiple sexual partners, contribute to the rising rates of HIV infection. When the men become the ones who undergo HIV testing first, the women usually find themselves forced to forgive them and stay with them. This was similar to the findings in this research, as client 3 knew about her own HIV status after her husband was tested HIV positive and she stayed and supported him until he died. Women often stay with infected partners because they are dependent on them financially and they sometimes have no other place to stay if they leave them (Paterson, 1996). This is what HIV-positive women experienced in this study as they suspected that they had contracted the virus from their husbands/partners. Client 9 indicated that when she disclosed her status to her

partner, he left her even though he was the one who had infected her. It was not easy for women to introduce the use of condoms with their longstanding partners once they had been diagnosed. Client 8 experienced difficulties with her husband regarding condom use. The women reported that they were insisting on condom use as they had been taught at the Wellness clinic to prevent re-infection.

This study revealed that the participants perceived people who were stigmatising as ignorant and not knowing their own status. For the women, it seemed that society had concluded that they were promiscuous. This perception obviously did not help them, as it made disclosure very difficult. Some participants' families reacted with shock and were hurt to learn that the women were HIV positive. After disclosure, however, the reactions ranged from negative to positive. Negative reactions included being chased out of home (client 7), not being taken care of when sick (clients 6 and 7) and being forced to have unprotected sex (client 8). The positive reactions included being well accepted by their families and offered the support they required.

Women often did not disclose their status because of a lack of trust in people. That either deprived them of the support they could have received from others or saved them from being stigmatised. The type of treatment that the participants received from others determined the manner in which they interacted with them afterwards. Clients 8 and 9 indicated that they had parted with their partners because of the way they were treated. Client 7 did not speak to her mother after the disclosure and experienced rejection from her father, but she derived much of her support from community members. Loss of interpersonal contact as Manuel et al. (1987) found in their study, contributed to women feeling isolated and lonely. Some women felt internal pressure to disclose to others. Smart and Wegner (1999) found that people who hide their status may struggle a great deal more than it appears. Although they may escape the immediate damage of negative social reaction, they probably experience internal conflict and become preoccupied with covering up their status.

6.2.5 Uncertainty about the Future

This research revealed that all the participants reacted to their HIV-positive status with shock, disappointment and irrational fear of the unknown. They feared dying a painful death. Client 3 indicated that she had witnessed her husband dying of this disease, which made her to become more fearful of HIV. AIDS has in fact become one of the most feared diseases in history and has killed millions of people (Hubley, 2002; Whelan, 2002).

Women dealt with their fear and uncertainties about the future by means of denial. They denied living with the virus or minimised the implications thereof by saying that they were living with tuberculosis (TB). Some women could not believe that they were indeed infected since they opted to confirm their diagnosis by being re-tested. Denial assisted them to temporarily cope with their emotions, the knowledge they had about dying soon and leaving their young children to

suffer. The fact that their lifestyle had to change drastically was also a disturbing factor to them.

Uncertainty about the future mainly originated from not knowing how long the women were going to live. This contributed too much stress. Client 10 indicated that following an HIV diagnosis, her husband immediately resigned from work and misspent all his money thinking that he was going to die soon, only to find that he was still alive a year later. Lack of support from some of the participant's relatives (clients 1, 2, 5, 6, 7, 8, 9 and 10) contributed to their feelings of uncertainty about the future, especially their fear about their children's plight when they were dead.

The following section contains a discussion of the development, implementation, interpretation and evaluation of the intervention and the way in which themes were addressed through cognitive behavioural therapy (CBT) techniques.

6.3 DISCUSSION OF THE IMPLEMENTATION AND EVALUATION OF THE INTERVENTION MODEL

The decision on how to address the themes during therapy was based on the women's need to deal with HIV and HIV-related stigma, and daily social problems they encountered. In this research the goals of psychotherapy were to assist HIV-infected women to cope with stigma by initiating a relationship with them; to elicit essential information; to produce some symptom relief and to instil hope that they can still live longer with the virus. All this was achieved through using CBT techniques (Bea & Tesar, 2002). Symptom relief made the participants feel better immediately and provided them with evidence that the CBT model can have a positive effect; thus it helped to build a treatment alliance (Allison & Denman, 2001). Table 6.1 demonstrates a summary of the researcher's perception of the effectiveness of each of the techniques that were used with specific clients to address each theme during the CBT therapy with clients. Although the focus of the qualitative analysis of the process notes was to understand women's reactions, the researcher summarised the findings in terms of the number of women for whom these techniques worked effectively to make a difference in their thinking patterns. The table will be used as a guideline for the discussion of the effectiveness of various cognitive behavioural techniques.

Table 6.1: Summary of the perceived effectiveness of various techniques

Techniques	Theme 1:	Theme 2:	Theme 3:	Theme 4:	Theme 5:
	Feelings of powerlessness	Feelings of guilt	Behavioural implications	The experience of the reaction of others	Uncertainty about the future
Positive cognitive reframing	9√ 1X	6√ 4X	6√ 4X	8√ 2X	8√ 2X
Teaching coping strategies	3√ 3X	2√ 2X	6√ 2X	7√ 2X	7√ 3X
Homework assignments	8√ 2X	10√	7√ 3X	8√ 2X	9√ 1X
Problem-solving skills	2√		1√ 1X	1√ 2X	1X
Decatastrophising	2√ 2X	3X	3√ 1X	5√ 5X	6√ 4X
Advantages and disadvantages	1X	1X		1√ 1X	1X
Identifying, challenging and changing underlying negative automatic thoughts and assumptions	3√ 3X	1√ 3X	2√ 2X	3X	1√
Education about HIV/AIDS	2√ 1X	1√		3√ 2X	
Positive self-statement logs			1√ 2X	1X	
Socratic questioning and reality testing	1√ 2X	1√ 4X	1√ 1X	1X	
Assertiveness training	1√	1X	2√	4√ 2X	7√ 2X
Role-play	1√ 1X	1√	1√	2√ 2X	
Graded task assignments		1X		1√	

√ means the technique was perceived to have worked for a particular number of participants and X means that the strategy did not work.

6.3.1 Feelings of Powerlessness

After the diagnosis, the participants could not make sense of what was happening to them and they perceived themselves as failures. Wisner et al. (1996) support this finding that HIV-positive women may, for example, experience irrational feelings of failure and worthlessness, which can be addressed and modified. Accepting themselves through the help of CBT and being accepted by others enabled the participants to develop hope that things will work out as reasonably as can be expected. The role of the researcher was to help women to

explore alternative ways of appraising their situation and to identify and change maladaptive thoughts, for instance, feeling useless and worthless.

Positive cognitive reframing which was mostly used to alter women's negative thinking pattern worked well in changing the way nine women perceived themselves by thinking positively about their disease. However, the technique was not effective with client 2 as she was not involved enough in therapy. Women were given homework assignments at the end of the therapy sessions, namely to think of how to boost their level of confidence. This was effective in further facilitating the process of change by making them aware that their disease should not be seen as lowering their confidence. The technique was not effective with two clients (clients 2 and 3 who were dealing with other social problems).

It must be stated that the researcher started with one technique and if it did apparently not have the expected reaction, other strategies were attempted to initiate change in their thought patterns. Therefore, all the techniques were not used with all the clients.

Because of the women's loss of confidence and self-worth in dealing with HIV and HIV-related stigma, which negatively affected their interaction with others, assertiveness training was role-played to two women. It proved to be effective for one client as she could assert herself, but not for the other client, probably because it may take more time to acquire the skill.

Six women were taught coping strategies aimed at change in life style and to care for their health. This was effective for three women, as client 4 indicated: "I now regard myself to be similar to others and I know that anyone can suffer from this disease". The suggested statements assisted women to accept their HIV/AIDS status, which helped them to gain self-confidence and self-worth. The strategy was not effective though for three women, possibly because the technique was administered at the beginning of therapy when the women were not yet ready to change their way of thinking.

Other techniques that were used less but made a difference were the following:

Recording of negative automatic thoughts assisted three women to recognise maladaptive thought patterns, such as over-generalisations and polarised thinking, and to substitute them with rational thought patterns (as described by Plotnik, 2002; Salkovskis, 1996; Wiser et al., 1996). Some women found the technique difficult to understand. They did not react to the challenge directly, though it could have started a process of change.

Through Socratic questioning and reality testing, the researcher showed three women how to change their maladaptive thinking patterns and this proved to work well for one client. Such cognitive restructuring brought relief in the session for client 3 who stated: "I don't have to regard myself to have low self-esteem because of this disease".

Once the women accepted their condition, they started exchanging their personal experience with others and teaching them about the disease. This played a pivotal role in the lives of the participants, since it helped them to reappraise their situation and thereby to find alternative ways of coping. This change was noted towards the end of therapy sessions in most of them (except for clients 2, 5 and 10).

Addressing this theme, the researcher assisted HIV-positive women to challenge their dysfunctional beliefs such as “being HIV-positive means that one is worthless” and to promote more realistically adaptive ways of thinking. Women were shown that HIV/AIDS does not cause a person to be worthless; it is their thoughts about HIV that contribute to this feeling. This approach worked well to change their thought patterns. Once they viewed HIV in a different light and considered it a challenge, their feelings and behaviour changed.

6.3.2 Feelings of Guilt

The intervention model aimed at helping the women to acquire coping strategies; to correct their faulty information processing; to help modify assumptions that maintain maladaptive behaviours and emotions; and to assist them to modify underlying cognitive structures in order to prevent relapse. This is also supported by the available literature (Bea & Tesar, 2002; Beck & Weishaar, 1989; Clark & Steer, 1996; Hollon et al., 1996; Mooney, 2000), which agrees that CBT techniques are effective in addressing irrational thought patterns.

The homework assignments that women were tasked to do (such as thinking about how it would help them to feel guilty about living with the virus) were most effective for all women in making them aware that such thoughts would not help. As a result, considering other ways of thinking about their disease – which were suggested through positive cognitive reframing – was effective in helping six women to cope with their disease. The other women could not immediately grasp this way of thinking.

Other techniques that were used less in addressing feelings of guilt included education about HIV/AIDS that was effective for client 4 as she came to realise that her anger that was directed towards her husband would not help her to cope. The researcher assisted the woman towards uncovering the belief system that results in anger and guilt. The goal of CBT was to challenge the validity of this underlying belief about herself in order to alleviate her anger and guilt (a strategy for identifying, challenging and changing underlying negative automatic thoughts and assumptions was used and it proved to work well for client 4). The other three women did not benefit from this strategy, possibly because they were not yet ready to change their way of thinking.

Teaching coping strategies were effective in assisting two women to deal with feelings of guilt. For example, client 7 was assisted to become aware of and confront her negative feelings. She was made aware of the social support she

received from others as a coping strategy. The other two women battled with the technique as the researcher tried one technique after another.

Socratic questioning and reality testing were also used to help women to modify negative thinking. They were told to evaluate and question their evidence for the automatic thoughts (as supported by Moorey, 2000), which proved to be effective for one client and did not work well for four women. These techniques were role-played for one client and proved to work well in uncovering the woman's automatic thoughts. They could have also been role-played for the other women, which would have possibly been effective to change their guilt feelings.

6.3.3 Behavioural Implications

The CBT model focused on changing particular behaviours that were harmful to the women, such as self-isolation and self-pity due to the stigma related to HIV/AIDS. The researcher empowered the women by changing and challenging their dysfunctional beliefs about their experience of internalised stigma and discrimination and promoted more realistic adaptive ways of thinking.

Women were tasked to think of how it would help them to pity themselves, making them aware that their current behaviour does not help them to cope. Thus the given tasks proved to be mostly effective for seven clients. As client 6 commented: "I do not have to feel pity for myself now that I have been empowered by you but I have to regard myself to be similar to other people and live my normal life". This shows that the homework assignments technique was effective. However the technique was not effective for three women as they did not complete their tasks.

Coping strategies were discussed with eight women and were perceived to be most effective with six. Women stated that they trust God to be in control of their lives now that they live with the virus and that He would help them to cope – this coping strategy assisted women to carry on with their lives. Women were further encouraged (as a coping strategy) to belong to support groups or to start support groups in their neighbourhood. This would provide a platform on which to unload their emotions, instead of feeling pity for themselves. This strategy assisted the women to feel good about themselves and they were further assisted by prayer, which formed an integral part of their coping strategy. These coping mechanisms were utilised to assist women to deal with the hurting emotions of being stigmatised and discriminated against. The technique was not effective for two women who were not involved enough in therapy.

Positive cognitive reframing was the third technique that further contributed to six women changing behaviours that were damaging to them by using their faith in God which helped them to reframe. Positive reframing helped to weaken the connection between their troublesome circumstances and habitual reactions such as fear or self-defeating behaviour. Women were taught to perceive themselves to be similar to others; having a chronic disease, like many other

diseases; and having to die like all other people who eventually will die. Four of the women did not react positively to these reframing.

Given the social problems that women experienced regarding the HIV-related stigma, assertiveness was taught to two clients who showed a lack of interpersonal skills. It proved to be effective for both women. Seeing that HIV-positive women expect people to discriminate against them, decatastrophising technique was used with four women to prepare them for the worst. The strategy proved to be successful with three women to help them anticipate the worst and think of themselves as not feeling bad about their disease. One woman did not benefit because of severe preoccupation about her son's discriminatory acts.

Cognitive techniques that were used at the start of therapy when the women were distressed included positive self-statement logs. For instance, three women were encouraged to write a list of good things about themselves as homework assignments rather than meditating on negative behaviours (suicide and self-isolation) (as supported by Beck, 1995; Beck et al., 1990; Moorey, 2000). The positive self-statement logs strategy made a difference for client 3, since she indicated that she still had children to take care of.

The intervention model aimed at relieving symptoms and resolving problems was effective by teaching problem-solving skills that client 1 used on a daily basis. For example, she was suicidal and pitied herself, thinking that her children's problems were the result of HIV. Talking to others about her status gave the woman the opportunity to solve problems effectively. The strategy was not effective with client 7 who was preoccupied about family rejecting her.

In further addressing the clients' self-pity and self-neglect, Socratic questioning and reality testing were used. Questions such as: "did you feel this way before the diagnosis and how come you feel that way now that you are living with the virus?" highlighted women's irrational thoughts related to HIV. This strategy assisted client 2 to draw her own conclusions and not to be told what to think. She realised that she need not have pity for herself but had to continue to cook for family gatherings. Moorey (2000) agrees that this strategy teaches clients to question the evidence for their automatic thoughts. The Socratic questioning and reality testing techniques were not effective with client 4 because it was possibly not necessary for her at that time.

Overall, the women seemed to accept the fact that they were living with the virus and learned how to behave when coming across stigmatising people and discriminatory acts. Towards the termination of therapy, some women reported that they now enjoyed talking to others publicly about the disease, be it at work (client 4), at home (clients 1, 3, 4, 6, 7, 8 and 9) or at church gatherings (clients 1 and 6).

6.3.4 The Experience of the Reaction of Others

In dealing with theme 4, success in therapy was facilitated by the women completing their homework assignments. It showed to bring about a positive change in their functioning.

While they reported that they were initially avoiding all contact with HIV information on the radio and television, they later showed to be accepting their disease, by freely talking about their status despite expecting to be stigmatised. Teaching coping strategies were effective for seven clients, as they indicated that they educated others about HIV. On the other hand, two women did not benefit as they had not yet accepted living with their disease.

When therapy started, it was difficult for the women to disclose their status to others. The decatastrophising technique was used specifically to assist women to consider the consequences of disclosure and that proved to be efficient for five clients. The participants were asked what would be the worst thing that could happen to them if they disclosed their status to others. In many cases it became clear that it was not so terrible after all once their fear of disclosing was confronted, and the women were assisted in how to disclose their status to others (Moorey, 2000). The women understood they could not expect everybody to accept them the way they are. On the other hand, five women did not gain from the technique and as a result, they were hiding their status in their social relationships, which enabled them to avoid the stigma and discrimination they were afraid of.

Behavioural techniques such as assertiveness and social skills training were used to empower four women to deal effectively with internalised and enacted stigma. Role-play was used to demonstrate assertiveness to four clients and it proved to be effective with two women. For example, client 1 was empowered to deal with stigma and discrimination since she no longer withdrew from social relationships and talked to neighbours and others at church about HIV. The other two participants did not benefit from assertiveness training and role-play since it takes time to acquire these skills.

Knowing how to deal with situations of enacted stigma enhanced women's feeling of control and was associated with being able to take charge of their lives and live the way they wanted to live. Giddens and Giddens (2000) agree that not being in control of a situation can leave someone feeling powerless. This was found to be in line with the research findings conducted by Mokhoka (2000). The researcher taught the women their basic human rights, such as anti-discriminatory laws, which greatly enhanced their coping, their ability to disclose their status and their interpersonal relationships.

6.3.5 Uncertainty about the Future

Given the women's uncertainty about the future, therapy was aimed at planning child care when the mother got sick. That was done through cognitive and behavioural methods using homework assignments. They seemed to contribute towards making nine women discover a purpose in life, which positively impacted on their emotional well-being and perception of life. The women were assisted to arrange with people they trusted to take care of their children when they die. Homework assignments that were successfully completed by women proved to be effective as they facilitated change in a positive way in-between therapy sessions (as supported by Beck et al., 1993).

The women were taught coping strategies to look at the brighter side of things, which was also effective for seven clients instead of thinking about the disease and its negative effects. They were taught stress management techniques in an endeavour to help them to cope. The use of a social support system played a significant role in enabling them to cope with stigma and discrimination, as well as with their uncertainties about the future. The other three women did not benefit from the strategy maybe because they did not need it at that time as it was taught towards termination of therapy.

In conclusion, the goal of therapy was to teach different techniques that could be incorporated into the women's lives. In this intervention most of the women became aware of their thought patterns and could change some of them into a more useful frame of reference that affected their feelings and behaviour. However, the researcher could not be sure that they would be able to use these strategies in their own lives outside the therapy situation again.

This section has provided a discussion of therapeutic techniques used to address the five commonly identified themes related to the experience of internalised and enacted stigma. In the process of discussion, the results were integrated with the previously discussed literature on the subject (Chapter 2) and the theoretical framework on how to facilitate change through psychotherapy (Chapter 3). The section that follows next will discuss the quantitative results.

6.4 THE QUANTITATIVE RESULTS

Following the implementation of the model, an outcome analysis provided an array of interesting results. The psychometric instruments were used to assess women's coping styles with the Brief Cope Scale (positive and negative coping), experience of stigma with the Internalised and Enacted stigma Scales, self-esteem with the Rosenberg Self-Esteem Scale (RSES) and depression with the Beck Depression Inventory-II (BDI-II) Scale before and after participating in the therapy. The psychometric post-therapy assessments confirmed the qualitative findings that women improved through psychotherapy. There were ten HIV-positive women who formed part of the experimental group and ten for the control group. A purposive sampling technique was used for this study (see

Section 4.3.3.1). A quasi-experimental design was used in the evaluation of the intervention (as described in Section 4.3.7.2).

On the Beck Depression Inventory-II (which is seen as a reliable indicator of level of depression) the experimental group's level of depression was statistically significantly mild post-therapy in comparison with the scores of a similar control group who did not receive therapy at the time. The women receiving therapy scored significantly lower, implying mild levels of depression. This can be interpreted that the intervention could have contributed to the change. This was corroborated by the findings of client 1 who showed to have improved significantly and experienced less depression (41 before; 12 afterwards), post-therapy. Some women in the experimental group were initially suicidal. According to Giddens and Giddens (2000) suicide is seen as a way to escape inner pain and depression, rather than working through problems. For example one woman indicated that she thought of killing herself and her children as it was hard for her to live with the disease, which was confirmed in item 9 of the BDI-II. Through having work assignments, women realised that they still had a purpose in life, such as raising their children. To a large degree, success in women's therapy was facilitated by the completion of the cognitive and behavioural techniques between sessions (Beck et al., 1993). It can therefore be noted that the intervention played a pivotal role in altering women's negative thinking patterns, resulting in mild levels of depression compared to the severe depression that they most experienced before therapy.

The experimental group showed significantly higher self-esteem after the intervention compared to the control group. The elevation in the women's self-esteem could possibly be contributed to their improved positive coping, after participating in the therapy. Wisner et al. (1996) support this finding that HIV-positive women may, for example, experience irrational feelings of failure and worthlessness, which can be addressed and modified – thus increasing the women's self-esteem. The positive change that was observed in client 2's evaluation confirmed that the participant was experiencing a higher level of self-esteem (13; 1), which further corroborated the effectiveness of the model. The coping strategies that women learned assisted them in regarding themselves to be similar to others, which further concurs with item 6 (I am as good as others) of RSES. Therefore this finding further validates these results, as it could be noted that the qualitative interviews were corresponding with the scores of women on the RSES.

Enacted stigma is the real experience of discrimination. No significant change was found in the experimental group's experience of enacted stigma compared to the control group's experience. In this instance, one can understand, given the nature of some of the options on this scale that is actions that already happened, such as: "I have been called bad names because I am HIV+". The responses of the women could indicate experiences that had happened before the intervention took place, since the questions in the post-test did not specify experiences since

the therapy started. Therapy would also not have made a difference in the community's reaction towards the client.

Internalised stigma is assessed using a scale developed and adapted from the questionnaire of Westbrook and Bauman (1996) for use in South African samples (Visser et al., 2008). The experimental group experienced high levels of internalised stigma due to HIV/AIDS before receiving therapy. This was further confirmed by their responses, as one client pointed out: "I feel that it is my fault that I contracted the virus and that I should have been careful enough". This is what is assessed in item 7 (I feel that it is my fault that I got HIV). The experimental group's level of internalised stigma was statistically significantly lower post-therapy compared to the control group. This means that the intervention could have influenced the score differences. The experimental group were better coping with internalised stigma as most of them accepted the disease and were talking to others about their disease. They were no longer feeling uncomfortable about people knowing about their status. Some of the women had started to date men and had changed their negative perception about the disease. The lower internalised stigma scores can be related to the cognitive reframing techniques used to change specific thoughts and behaviours (as supported by Plotnik, 2002).

The Brief Cope Scale (Carver, 1997) was used to determine the coping responses of participants. Positive coping assesses types of behaviour such as, positive reframing, religion and acceptance, while negative coping scale assesses types of behaviour like denial, substance abuse, self-blame as negative ways to cope. The experimental group showed significant increases in positive coping post-therapy compared to a similar control group. Their participation in the study led to further positive coping, such as thinking positive about their disease and positive lifestyle changes, which were achieved through CBT techniques and were reflected in the post-therapy assessments. For example, client 10's findings corroborated the effectiveness of the intervention model as it was noticed that she experienced positive coping (27; 38) post-therapy.

Before therapy the women used various negative ways of coping, as they have been giving up the attempt to cope with their disease and were criticising themselves for living with the disease. This corresponds with the qualitative data from phase 1 interventions. For example, a client said: "I have been blaming myself for contracting this virus ..."

The women displayed significantly less negative ways of coping following their involvement in therapy, compared to a similar control group. Many of the women indicated that their lives had changed for the better and that they had made changes in their lifestyle, since they began to be involved in therapy. The women initially denied to be living with the virus, while they accepted their status after therapy.

It can therefore be concluded that the intervention had a positive impact on the women as all their psychometric scores improved significantly after therapy compared to the control group. The findings also indicate that the same patterns of experiences and behaviour were found in the quantitative results and the qualitative interpretation of women's reactions to the therapy.

In conclusion, the intervention model could be seen as effective in this study because it enabled some clients to deal with suicidal ideations, low self-esteem, fear of death, anger and depression, self-pitying behaviour, uncertainty about the future, and the potentially stigmatising and discriminatory reaction of others. Therefore, some clients had empowered others to cope with the disease, which suggests that change took place and that they are coping well. Though it was a small sample of women participating in the research, the use of different methods to obtain comparable data confirmed the validity of the results. Next, the discussion will focus on the strategies that did not prove to be effective.

6.5 THE COGNITIVE BEHAVIOURAL THERAPY TECHNIQUES THAT DID NOT FUNCTION WELL

The techniques that did not work well were at times due to the structured nature of the intervention model that seemed to limit the effectiveness of the intervention. Sometimes the homework assignments that were given seemed not to be relevant since the women were dealing with other issues. As such, the intervention became like a recipe; even the content of the techniques, which more or less remained the same. This was done for the sake of giving similar intervention to all participants as part of controlling variables in the research design. The content of the intervention was therefore not always appropriate for the specific needs of the specific client at that moment. The therapist could also have related more to the clients' understanding of the problem and what it meant to them before giving his statements.

CBT techniques that were not successful were possibly as a result of the low level of intelligence that some of the women displayed, as intelligence plays a pivotal role in understanding the techniques that were used to make clients aware of their cognitive processes and they did not really learn the skills possibly as a result of low level of intellectual functioning. For example, advantages and disadvantages technique proved to be not effective with client 10 and the skill can work with others. It must be pointed out that some of the techniques may not have an immediate effect on the clients but they could contribute to the development of a climate for change.

The participants' ill health also contributed to the clients not grasping the line of reasoning. For example client 2 did not complete any of her homework tasks due to ill health. The therapist was unsure how to engage her in therapy – as such he did most of the work by giving new interpretations. The positive self-statement logs strategy proved not to be effective with clients 4 and 10, and should perhaps have been repeated in other sessions to make it more effective. Another reason

for its failure was that it was difficult for the therapist to engage client 10 in therapy and she did not understand this technique.

Assertiveness training proved to be not effective for some of the women, mainly because it takes time to develop assertiveness and not enough attention was given to it for the clients to grasp the skill. The technique could have been role-played more in order to facilitate clients learning the skill.

Due to the social problems women experienced on a daily basis and fear of stigma and discrimination they were faced with, client 7 did not benefit from problem-solving skills and graded task assignment because she was preoccupied with family members who discriminated against her and she did not do her assigned task.

Identifying, challenging and changing underlying negative automatic thoughts and assumptions strategies proved to be not effective with clients 4, 5 and 8, as they did not understand these skills because they were administered at the beginning of therapy when it was still difficult for them to deal with stigma. Therefore, the skills could have been repeated later in therapy so as to impact the process of change in a positive way.

It was difficult for some of the women to grasp the line of reasoning for Socratic questioning and reality testing techniques. The reason for the failure could be that the women could react to a challenge but that they would not be able to do self-challenge. Though this could have contributed to different thinking, the researcher doubt if they would be able to do these themselves after therapy. So, they possibly benefited from the experience but did not learn the skill as an empowering tool. On the other hand, the researcher wanted the women to participate actively in questioning their own assumptions, but this never worked.

Although CBT is didactic and confrontational about the client's irrational thoughts, the researcher appeared to be talking too much during therapy sessions and at times interpreted most of the techniques for the women. As a result, women were often bombarded with words as he used one technique after the other to try to get feedback from the client. This could have resulted in the clients being passive and not understanding the techniques that were taught. Therapy might also have scared the women because they were not used to a different way of thinking. In that way the researcher might have lost some of the women, such as clients 2 and 10.

The 'therapist effect' was unavoidable since the participants were aware of being observed and the researcher was asking questions during the therapy sessions in an attempt to assist women to deal with HIV and HIV-related stigma. All these therapeutic sessions were tape recorded which may have had an effect on the outcome of the results. It was therefore important to try to reduce the researcher/ 'therapist effect' by making the women as comfortable with the therapeutic process as possible. Other factors over which the researcher had no control,

such as his gender, race, physical appearance and background, may have had an effect on the responses provided by participants. Often there is danger that HIV-positive women may view a professional male as an intruder who may not understand their experiences. These factors could cause participants to provide biased or even false information (Huysamen, 1994; Judd et al., 1991; True, 1989). As a psychologist in a professional relationship with his clients, the researcher established a relationship of mutual trust with the participants and convinced them of the confidentiality of their information and the harmlessness of the study. That is why the level of intimate information the participants shared with the researcher showed that they trusted him as the therapist. Suggestions for the implementation of this intervention in future will be discussed next.

6.6 SUGGESTIONS FOR FUTURE IMPLEMENTATION

From the results of the study, suggestions can be made on how the intervention can be changed and implemented in a therapeutic relationship with women.

In implementing the model, the therapist should use the model in a flexible way to relate to the client's problems rather than to follow the model strictly. In this research the strict application of the model was done for research purposes. Though, this resulted in spending time on aspects that were not too serious for participants, while their attention was concentrated on other issues. This resulted in the participants not reacting as expected in response to some techniques.

Clients should be given the chance to draw their own conclusions about their situation or feelings/thoughts and be given time to absorb the meaning of suggestions and time to react at their own pace. In this research, it resulted in bombarding the clients with several techniques, as it was seen with client 2 who remained passive with only some new insights coming through to her. Clients should not be spoon-fed about what to think, as some of the strategies teach clients to question the evidence for their automatic thoughts. Relevant homework assignments should be given to the clients so as to facilitate the process of change.

When using CBT, the average level of cognitive functioning should be considered in order to understand the strategies to change women's thought patterns. For instance, clients 2 and 10 could not be engaged much in therapy, maybe because of their low level of intelligence and them not openly discussing aspects pertaining to HIV/AIDS and HIV-related stigma. Thus, cognitive therapy would be more appropriate for clients' average level of intellectual functioning. When cognitive techniques do not provide the expected results, more behavioural level techniques may be included.

It must be noted that it might take more time to teach skills such as assertiveness training that cannot be done in one session. To learn self-reflective skills and to change clients' thought processes is a long-term strategy that needs more time.

In order for the model to be effective, only the techniques that worked well should be utilised, rather than using too many techniques. In this way the teaching component can also be more effective. If the technique is not successful the first time, it can be repeated and the client can be guided towards change. Suggesting something can start a change process although the women might not be ready to grasp it. After a session they may be more equipped to use the skills. In the long term this can be effective, because the women would be enabled to start looking at things from another angle and not only listen to what the therapist has to say.

The CBT techniques that were most effective with the majority of the women that can be used with success in future application are positive cognitive reframing, learning coping strategies, homework assignments, decatastrophising and assertiveness training.

The other techniques that were used less with this group, though they could have started the change process are suggested that they could have been repeated until the women changed their irrational thought patterns. These techniques are problem-solving skills, advantages and disadvantages, identifying, challenging and changing underlying negative automatic thoughts and assumptions, positive self-statement logs, Socratic questioning and reality testing, role-play and graded task assignments.

6.7 LIMITATIONS OF THE STUDY

Despite the fact that this study has succeeded in providing an intervention model that resulted in change in various psychological variables, there were some aspects that could have a negative effect on the validity of the results. This study was conducted within a selected group of black HIV-positive women, who live in an urban area and have access to medical care such as counselling and medical treatment. Therefore, the findings of this study cannot be generalised to all women, especially those living in rural areas, or to other groups. This is because of the diversity of cultures, backgrounds and socio-economic classes of other women. Because of the qualitative nature of the study, generalisation of the results was never an aim.

More women could have been used in the study, which might have changed the conclusion about the effectiveness of the techniques used. Nevertheless, using a small number of women had certain advantages, because it enabled the researcher to study the reaction of the women and to evaluate the value of each CBT technique. The study topic was very sensitive, and it must be pointed out that it was difficult to talk about the experience of HIV/AIDS and the clients' disclosure of their status. It was also not practical to include the women's partners and their families in the study, which would have given interesting views about how the women and their families coped with the stigma related to HIV/AIDS. It would also have shown how they were affected by what the women

were experiencing and that might have had an impact on the recommendations of the model.

All the interviews were tape-recorded and this may have intruded on the therapy process, despite the women having been reassured of the anonymity and confidentiality of their information. Though, the intimate nature of the participants' disclosure suggests that this was not a real problem for them. Original interview data was not coded because the interviews had to be transcribed and translated into English. As a result, information might have been lost during the process of transcription and translation, which is a limitation of this study.

The interpretation of the outcome of the research was done by the researcher/therapist who was very involved in the process of therapy. Nonetheless the researcher was assisted by his male colleague who also interpreted Phases 1 and 2 results to avoid biased interpretation. The researcher's biasness came in the researchers' "eagerness" to see results. He was tense and wanted to see changes, therefore he used one technique after the other to be able to implement change. He could have been more patient and allowed the client more time to make her own conclusions. In future research it may be beneficial to train a few therapists to implement the intervention and to evaluate the results and not having the researcher as the only therapist – that will enhance the validity of the intervention outcome.

The incentives that were provided for participants (that is, money for transport and food) may have affected the outcome of the study. This is still possible even if the women signed informed consent, as this motivation could range from genuine interest in assisting in the research as a participant to an expectation of some sort, for example, offering help whenever it is needed. However, the validity of the research was corroborated by the reliability of scales that was confirmed by multi-methods. The following section will discuss conclusions drawn from this research.

6.8 CONCLUSION

This study has developed, implemented and evaluated a cognitive behavioural therapy (CBT) model to assist HIV-positive women to deal with stigma. From the outcome of the evaluation it can be concluded that the model was successful in helping HIV-positive women to cope with their diagnosis and the stigma related to HIV. The intervention model can be recommended to practising psychologists to empower HIV-positive women in dealing with internalised stigma and discrimination and to assist people living with HIV/AIDS to cope.

This study revealed that being HIV positive and trying to cope with stigma and discrimination involves diverse experiences for women, although there are common themes for all participants. After their diagnosis, all the participants experienced some common irrational thoughts related to HIV and anticipated to be stigmatised. The negative feelings they experienced varied from anger,

worthlessness, loss of confidence, regrets, suicide, self-pity, self-isolation, denial, shock, fear of the unknown, hurt, confusion and depression. Disclosure of their status was difficult to all participants because they anticipated being stigmatised.

This research shows that the level of internalised stigma possibly stems from the individual's own perception of HIV and fears they may have that others may discriminate against them. When a person is diagnosed with HIV, he/she expects people to react negatively and much of the stigma becomes internalised. Because they expect people to react negatively, they do not disclose their status and select only those people whom they think they can trust, to disclose to. This possibly results in them experiencing low levels of enacted stigma. To assist women to cope, their own internalised perception of HIV needs to be addressed.

The findings of this study indicate that women experienced less scores on depression, internalised stigma, negative coping, self-esteem, as well as higher scores on positive coping after having participated in eight therapy sessions. The five psychometric post-therapy assessments confirmed the qualitative findings that women improved through psychotherapy. These findings also indicate that the same patterns of experiences and behaviour were found in the quantitative results and the qualitative interpretation of women's reactions to the therapy. It can be noted that where qualitative and quantitative methods have often been used together in the same research project and in many cases such integration has resulted in increased validity, as seen in this research where results obtained through one method can be confirmed by means of different data sources (Casebeer & Verhoef, 1997).

Through using CBT as a theoretical framework in this population, the researcher noted that the strategy is directive, instructional and it is known that the therapist is active and do most of the talking. In this research the researcher as a therapist found that he must be on the level of the client. He must first understand what the client is saying and give acknowledgement that he understands before he confronts irrational thoughts and suggests alternative ways of thinking. When confronting immediately it seems as if the client keeps on explaining what she means, while the therapist take another line of reasoning – they become in opposition. The client cannot hear what the therapist is saying. By first understanding and then suggesting an alternative, the therapist may engage the client easier in thinking of alternative solutions. Following the client and moving at the client's tempo is also a way of engaging the client rather than to give too much information. The client needs to absorb what is been said, discuss it, make it applicable in his/her situation, express concerns before he/she can try it out and integrate it into his/her behaviour. This is a long process that cannot be seen immediately in a session.

Lastly, this is a programme to assist women, but more work need to be done on community level to lower the stigma people attach to HIV. This model could be disseminated as widely as possible to assist women to cope.

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APPENDIX A

GUIDELINE QUESTIONS FOR THE INTERVIEWS

1. How do you feel about being diagnosed with HIV?
(The researcher's focus will be based on the participant's fear, loss, grief, guilt, denial, anger, anxiety, suicidal ideation, low self-esteem, depression, obsessive conditions and spiritual concerns.)
2. What is your understanding of the disease you are suffering from?
(The researcher will be assessing the participant's background, knowledge and the meaning attached to the disease.)
3. How do you feel about this disease that requires a lot of care, lifestyle changes, commitment and discipline?
4. How did it affect you to know that you are HIV positive?
5. Whom did you tell about your HIV status and what was their reaction?
6. Have you had any experiences where you were treated badly because of your HIV?
(I know that this might be difficult for you but could you please describe this experience for me.)
7. What is your future like, now that you are HIV-positive?
8. Tell me more about your family.
(The researcher will be assessing the participant's support system.)
9. How do you cope with this disease?
(The researcher will be assessing how the participant deals with the possibility of facing death sooner; stigma and discrimination surrounding HIV/AIDS; changes or possible changes in her body image; HIV-related symptoms; stigma that people attach to HIV; ways in which her HIV diagnosis has changed her life; coping with intimate and family relationships.)



APPENDIX G

MPUMALANGA PROVINCIAL GOVERNMENT

Number 7
Government Boulevard
Riverside Park
Extension 2
Nelspruit
1200
South Africa



Private Bag X11285
Nelspruit, 1200
Tel: (013) 766 3429/30
Int: +27 13 766 3429/30
Fax: (013) 766 3458
Fax: +27 13 766 3458

Department of Health and Social Services

Litiko Letemphilo Nemisebenti
Yenhlalakahle Yesive

Umnvango WezePilo
neZehlalakahle

Departement van Gesondheid
en Maatskaplike Dienste

Enquiries: **Nkhumisani Mphathele (013) 766 3235**

Mr. J. Tshabalala

P.O. Box 3504

Witbank

1035

24 April 2006

**APPLICATION FOR RESEARCH ETHICS APPROVAL: A MODEL OF
COGNITIVE BEHAVIOURAL THERAPY FOR HIV+ WOMEN TO DEAL
WITH STIGMA**

The research committee has approved your research proposal. No ethics consideration for concern identified.

Kindly ensure that you provide us with the report once your research has been completed.

Kind regards,

 _____

Miss N.A. Mphathele

Research—coordinator

Pp: Mpumalanga PHREC

24/04/2006

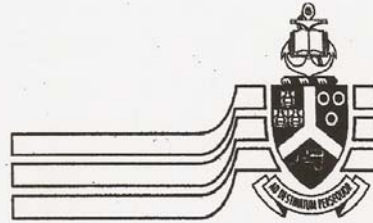
Date





APPENDIX H

Members:
Research Proposal and Ethics Committee
Dr P Chiroro; Dr L Davis; Prof C Delpoit;
Dr JEH Grobler; Prof KL Harris; Prof E Krüger;
Prof B Louw (Chair); Prof D Prinsloo;
Prof G Prinsloo; Dr E Taljard; Prof H van der Mescht;
Prof J van Eeden; Prof A Wessels; Mr FG Wolmarans



University of Pretoria

Research Proposal and Ethics Committee
Faculty of Humanities

28 November 2005

Dear Professor Visser

Project: *A model of cognitive behavioural therapy for HIV-positive women to assist them in dealing with stigma*
Researcher: J Tshabalala
Supervisor: Prof MJ Visser
Department: Psychology
Reference number: 25519175

Thank you for the application you submitted to the Research Proposal and Ethics Committee, Faculty of Humanities.

Please note that the letter of informed consent needs to be printed on a University of Pretoria letterhead before it is distributed to the participants.

The Committee requests that proof be provided of the Mpumalanga Department of Health's permission for the project.

I have pleasure in informing you that the Research Proposal and Ethics Committee formally approved the above study on 24 November 2005. The approval is subject to the candidate abiding by the principles and parameters set out in his application and research proposal in the actual execution of the research.

The committee requests you to convey this approval to Mr Tshabalala.

We wish you success with the project.

Sincerely

Prof Brenda Louw
Chair: Research Proposal and Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA



APPENDIX I



University of Pretoria
Pretoria 0002 Tel (012) 4204111

22-12-2005

Faculty of Arts

INFORMED CONSENT FORM

I, _____, am being asked to participate in a research project to develop and evaluate a way of helping people to deal with stigma and discrimination.

The researcher (Jan Tshabalala) has explained the nature of this study to me. I understand that the anticipated benefits of my participation are to enable health care professionals to effectively help people to cope with their daily lives and to deal with the experience of stigma and discrimination.

The researcher will make every effort to safeguard the confidentiality of the information that I provide. Any information obtained from this study that can be identified with me will remain confidential and will not be given to anyone without my permission.

If at any time I would like additional information about this project, I can contact the researcher at 082 379 0416.

I understand that I have the right to refuse to participate in this study. I also understand that if I do agree to participate, I have the right to change my mind at any time and stop my participation. My signature below indicates that I have given my informed consent to participate in the above-described project. My signature also indicates the following:

- I have been given the opportunity to ask questions about the described project and my participation in it.
- My questions have been answered to my satisfaction.
- I have been permitted to read this document and have been given a signed copy of it.
- I am at least above 18 years old and legally able to provide consent.

Signature of participant

Date

Signature of researcher

Date

APPENDIX J



University of Pretoria

Pretoria 0002 Tel (012) 4204111

27-05-2006

Faculty of Arts

INFORMATION ABOUT THE RESEARCH PROJECT FOR WOMEN TO ASSIST THEM IN DEALING WITH STIGMA

You are being asked to participate in a project to develop and evaluate a way of helping women to deal with stigma. Such an intervention may enable health care professionals to help other people to cope with their daily lives and to deal with the experience of stigma and discrimination.

To participate in the project you will have to attend sessions with the clinical psychologist at the hospital. He intends to help you to talk about your experiences and how to deal with difficult situations you may encounter. Given the sensitivity of the nature of the research project, kindly note that there may be some emotional discomfort as you talk about your experiences of stigma related to HIV/AIDS. For instance, it is possible that you may have lots of emotions to express such as crying, feeling sad and so on. The researcher will be sensitive when dealing with your personal information in order to protect you from harm (that is, physical, emotional and any other kind).

We ask you to voluntarily participate in the project. Remember that you have the right to refuse to participate and if you *do* agree to participate, you have the right to change your mind at any time and stop your participation.

The following measures will be implemented to protect you:

- The researcher is practicing as a clinical psychologist and is bound by professional ethics to keep information strictly confidential. You will be protected from unwarranted physical or mental discomfort or distress.

- The information about the session will be kept in a locked cabinet with a number as the only identification to ensure that the information cannot be associated with you as a person.
- The researcher (who is a practicing clinical psychologist) will offer you intensive psychotherapy in order to assist you to cope effectively.
- The research is done under strict supervision of a senior psychologist with ethical clearance of the University of Pretoria, the Witbank Hospital management and the Mpumalanga Department of Health.
- Results of the study will not be published in any way with your identity attached to it.

Information on the project can be obtained from:

Jan Tshabalala (Psychologist at Witbank Hospital) 082 379 0416

Prof. Maretha Visser (Supervisor, University of Pretoria) 012 420 2549

APPENDIX K

A summary of all the case study scores of five HIV-positive women

Participant	Coping - negative	Coping - positive	Personal stigma	Enacted stigma	Self-esteem	Depression
1	15	28	41	10	14	25
2	28	36	27	3	3	10
3	21	42	33	2	4	12
4	27	43	31	2	0	5
5	27	40	22	0	0	8

APPENDIX L

A summarised table of the quantitative results on the five psychometric scales

Participant	Group	Coping - negative (before)	Coping - positive (before)	Personal stigma (before)	Enacted stigma (before)	Self-esteem (before)	Depression (before)	Coping - negative (after)	Coping - positive (after)	Personal stigma (after)	Enacted stigma (after)	Self-esteem (after)	Depression (after)
V1	V2	V3	V4	V5	V6	V7	V8	V9	V10	V11	V12	V13	V14
122BB	Experimental	13	43	44	6	8	15	24	43	19	1	0	1
123CC	Experimental	16	42	33	7	13	24	28	47	27	6	1	10
124DD	Experimental	30	42	32	6	4	19	29	44	27	7	0	9
125EE	Experimental	18	38	46	8	4	41	31	47	23	3	0	12
126FF	Experimental	27	27	46	2	10	25	31	38	22	1	2	10
127GG	Experimental	18	26	36	7	14	40	30	41	20	4	2	8
128HH	Experimental	12	32	38	7	11	48	26	43	26	10	0	18
129II	Experimental	27	37	27	2	13	13	29	42	19	0	0	4
130JJ	Experimental	12	45	43	14	6	39	27	48	22	4	0	9
131KK	Experimental	30	38	32	0	2	17	26	41	21	2	2	8
001	Control	24	24	51	7	20	33	19	25	45	7	19	31
002	Control	17	24	41	5	17	34	15	22	40	6	14	40
003	Control	24	21	51	12	19	29	25	25	50	13	15	26
004	Control	25	45	40	1	10	28	28	42	42	2	9	29
005	Control	13	28	38	6	8	21	18	31	40	5	8	24
006	Control	22	46	44	11	3	19	21	34	38	3	4	27
007	Control	23	38	30	3	10	20	23	42	22	0	2	16
008	Control	27	37	50	7	7	21	23	39	38	11	3	23
009	Control	25	26	37	9	2	16	30	31	27	4	0	11
010	Control	25	43	42	0	0	22	24	48	21	0	0	10