

**Stigma, Psychological Functioning and Efficacy of Stigma Reduction Intervention
among People Living with HIV and AIDS in Limpopo Province**

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Declaration

I, MANTWA WELHEMINA MODIBA, hereby declare that this thesis submitted by me for the award of Doctor of Philosophy in Psychology at North-West University is my own independent work, and has not been previously submitted by me at another university. All materials within this document have been duly acknowledged.

Modiba MW

Date

Dedication

This work is dedicated to my exceptional loving and caring mother (BoMmane, as we affectionately call her), Mrs Moagabo Meriam Bopape. Thank you for your enormous support, constant and tireless prayers throughout this academic journey. You taught me to believe and to have faith in God while I was still a child, not only by teachings, but you modelled that to date. Your teachings became very instrumental in this journey, thank you. When times were tough and when I was getting weary, you kept on praying like never before, that kept me going. You saw it through the end, thank you Mmane (mother). God bless you!

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ABBREVIATIONS

AIDS	=	Acquired Immune Deficiency Syndrome
ART	=	Antiretroviral Therapy
ARV	=	Antiretroviral
HAART	=	Highly Active Antiretroviral Treatment
HIV	=	Human Immunodeficiency Virus
PLWHA	=	People Living with HIV and AIDS
PLWHPT	=	People Living with Hypertension
SCSI	=	Stigma Coping Skills Intervention

ABSTRACT

There is still a high prevalence rate of stigmatisation of people living with HIV and AIDS (PLWHA) in South African communities. HIV and AIDS stigma has been demonstrated to have adverse effects on the psychological functioning of people living with HIV and AIDS. The main aims of this study was twofold: 1) to determine HIV and AIDS stigma experiences and psychological functioning among PLWHA in Limpopo Province, South Africa, and 2) to design, implement, and to empirically evaluate the efficacy of an HIV and AIDS stigma reduction intervention.

Adopting a two phase study approach, the study was anchored on a cross-sectional design for phase I, and a pre-test post-test two group design for phase II. Phase I study was a baseline assessment of HIV and AIDS stigma experiences as well as determination of psychological functioning among PLWHA with a cohort of people living with hypertension (PLWHPT), while phase II focused on empirically tailoring an HIV and AIDS stigma reduction intervention, the Stigma Coping Skills Intervention (SCSI). To determine HIV and AIDS stigma, the HIV and AIDS stigma scale was used, while the GHQ 28 was used to determine psychological functioning. A total of 600 participants were utilised for phase I study, 300 were assigned to the experimental group (PLWHA) and 300 to the control group (PLWHPT). Purposive sampling method was employed for phase I study. For phase II study, a total of 24 participants were employed, assigned to two groups (12 participants experimental and 12 control). Simple random sampling method was used for the phase II study.

Findings indicated that PLWHA experienced significantly higher levels of enacted stigma ($t=-11.79$, $P< .001$) over other stigma dimensions, and poorer psychological functioning than PLWHPT ($t= -3.43$, $P< .001$). Relatively, PLWHA experienced significantly less internalised ($t=37.56$, $P< .001$) and perceived stigma than PLWHPT ($t=41.71$, $P< .001$). Enacted HIV and AIDS stigma had a significant direct positive relationship with psychological dysfunctions ($\beta = .198$, $p<.01$), and was found to significantly predict psychological dysfunctions. Enacted HIV and AIDS had a significant direct negative relationship with age ($\beta = -126$, $p<.05$), and non-significant direct negative relationship with duration of diagnosis. Age was found to have significant direct negative relationship with psychological dysfunctions ($\beta = -.140$, $p<.05$). Duration of diagnosis had a non-significant direct negative relationship with psychological dysfunctions. The SCSi demonstrated efficacy in HIV and AIDS stigma reduction, as well as improving psychological functioning.

HIV and AIDS stigma is still pervasive and continues to negatively impact the psychological functioning of PLWHA. The SCSi is effective in reducing HIV and AIDS stigma and psychological dysfunctions among PLWHA. It would be beneficial to integrate psychological interventions into the routine treatment programmes for PLWHA, for prevention of the development of psychological dysfunctions, and treatment, which will help break the psychological dysfunctions-induced vicious cycle of HIV transmission.

Key words: Age, Duration of diagnosis, HIV and AIDS stigma, PLWHA, Psychological functioning

CHAPTER ONE

1. INTRODUCTION

1.1 Background of the Study

HIV and AIDS stigma is widespread, experienced in almost every country and region of the world (Senyalo, Maja, & Ramukumba, 2015; Yu, Zhang, & Chan, 2016; Yuh, Ellwanger, Potts, & Ssenyonga, 2014). In HIV and AIDS care, HIV and AIDS stigma is the most frequently reported problem (Brent, 2016; Hutton, Misajon, & Collins, 2013; Niu, Luo, Liu, Silenzio, & Xiao, 2016). HIV and AIDS stigma has been recognised to be critical in the development of psychological dysfunctions among People Living with HIV and AIDS (PLWHA) (Iwelunmor & Airhihenbuwa, 2012). Due to HIV and AIDS stigma, PLWHA are more vulnerable to develop psychological dysfunctions.

HIV and AIDS stigma also continues to foster the spread of the pandemic (Chan, Tsai, & Siedner, 2015; Gilbert, 2016; Liamputtong, 2013). For instance, about 36.9 million people globally were reportedly infected with HIV in 2014, which is an increase from 29.8 million in 2001, with about 5,600 new infections per day. Of this global prevalence, approximately 70% are recorded in Sub-Saharan Africa (UNAIDS, 2015). South Africa is regarded as one of the countries with the highest prevalence of people living with HIV and AIDS (PLWHA) globally (Malla, Middelkoop, Mark, Wood, & Bekker, 2013; Shisana et al., 2014). For example, in the mid-year of 2014, the South African population was estimated at 54 million, and the overall HIV prevalence rate was estimated at approximately 10, 2%.

During the same period, South Africa noted an estimated increase of about 1.42 million cases, from an estimated 4, 09 million in 2002 to 5,51 million by mid-2014 (Shisana et al., 2014). Thus, despite extensive improvements in HIV prevention, care and less burdensome treatment regimens (Yi et al., 2015; Gupta, Williams, & Montaner, 2014), HIV transmission is still continuing.

The efforts to fight the spread of the pandemic are stalled by persistent stigma (Brent, 2016) and its harmful psychological effects on those living with the virus (Hutton et al., 2013; Niu et al., 2016). The prevalence of psychological dysfunctions in PLWHA is pervasive (Chambers et al., 2015) and highly associated with HIV and AIDS stigma (Yi et al., 2015; Yu et al., 2016). HIV and AIDS stigma has a tremendous negative impact on the psychological functioning of PLWHA (Liamputtong & Kitisriworapan, 2012; Sorsdahl, Mall, Stein, & Joska, 2011; Nyblade, Stangl, Weiss, & Ashburn, 2009), more than the non-infected (Sikkema, et al., 2015). Notably, HIV and AIDS stigma experiences among PLWHA is associated with elevated stress levels, depression (Bhatia & Munjal, 2014; Ofovwe & Ofovwe, 2013; Onyebuchi-Iwudibia & Brown, 2014; Rael & Hampanda, 2016, Rueda et al., 2011), high suicide rates (Wu et al., 2015), post-traumatic stress disorders (PTSD) (Dabaghzadeh, Jabbari, Khalili, & Abbasian, 2015; Yi et al., 2015), substance use disorders (Durvasula & Miller 2014), and neurocognitive disorders (Chibanda, Benjamin, Weiss, & Abas, 2014).

Amongst the psychological dysfunctions, the prevalence of depression among PLWHA is particularly high (Relf, Eisbach, Okine, & Ward, 2013), estimated at two to five times more than that of the general population (Elenga et al., 2014).

Also, PLWHA with comorbid depression reportedly progress rapidly from HIV to AIDS relative to non-depressed PLWHA (Boarts, Buckley-Fischer, Armelie, Bogart, & Delahanty, 2009), which demonstrates the adversity of poor psychological functioning in this population. Furthermore, due to stigma, PLWHA often internalise feelings of shame (Engebretson, 2013), guilt and self-hatred, precipitating internalised HIV and AIDS stigma, while some experience denial of the positive sero-status (Lyimo et al., 2014). Most PLWHA experience the actual loss of social support from family and friends, and social avoidance (Grodensky et al., 2015), precipitating enacted HIV and AIDS stigma, while some experience a perceived sense of other people not being comfortable around them due to their HIV positive status, precipitating perceived HIV and AIDS stigma (Cahill & Valadéz, 2013), which contributes to high experiences of psychological dysfunctions.

As such, excessive psychological dysfunctions from HIV and AIDS stigma create a hostile living environment for PLWHA, resulting in poorer psychological functioning. Research findings indicate that when HIV and AIDS stigma persists, the hostile living environment erodes PLWHA's coping mechanisms over time, resulting in reduced capacity for coping with new stressors, precipitating even poorer psychological functioning (Bogart, Wagner, Galvan, Landrine, & Klein, 2011). As a result, HIV and AIDS stigma and psychological dysfunctions remain major problems for PLWHA. Yet, studies intended to alleviate HIV and AIDS stigma and psychological dysfunctions among this vulnerable population are scarce (Yuh et al., 2014), particularly in South Africa.

In order to be able to design an effective intervention programme to deal with HIV and AIDS stigma and psychological dysfunctions, insight into the factors that make HIV a highly stigmatised disease is vital. Factors such as pre-existing stereotypes and prejudices (Link & Phelan, 2001) have been recognised to influence stigmatising attitudes, resulting in HIV and AIDS often being perceived as associated with moral concepts of blame, responsibility and deservedness (UNAIDS, 2013).

In this view, PLWHA are often blamed as having brought the disease upon themselves by engaging in socially, culturally or morally prohibited or condemned behaviours (Fielden, Chapman, & Cadell, 2011, Patel et al., 2012). This is because morality is fundamental to African principles (Idemudia, 2003) which make HIV a comparatively highly stigmatised medical condition (Corrigan et al., 2000; Daftary, 2012, Idemudia & Matamela, 2012). That is, the association made between HIV and AIDS and sex, drugs, homosexuality, contagion and an unpleasant form of death, makes it a powerfully stigmatised disease (DeMarco & Cao, 2015; Mukoloa et al., 2014). Thus, HIV and AIDS is highly stigmatised owing to negative societal preconceptions allied with the negative associated behaviours. As a result, such adverse societal preconceptions are the precursors of stigma and subsequent psychological dysfunctions among this population relative to other conditions. Despite that, not many comparative studies of HIV and other medical conditions on experiences of stigma and psychological dysfunction among PLWHA have been conducted, especially in South Africa, hence the current study included people living with hypertension (PLWHPT).

In addition to fuelling psychological dysfunctions, HIV and AIDS stigma continues to perpetuate social disparities (Wolitski, Pals, Kidder, Courtenay-Quirk, & Holtgrave, 2009) related to issues such as but not limited to age (Earnshaw & Chaudoir, 2009; Liamputtong, Haritavorn, & Kiatying-Angsulee, 2009), as well as duration of diagnosis (Cahill & Valadéz, 2013). Research demonstrates these aspects to be inter-related, and to accelerate the spread of the epidemic in South Africa (Fielden et al., 2011). As a result, dynamics surrounding age and duration of diagnosis in relation to HIV and AIDS stigma and psychological dysfunctions will be explored in the present study which will assist to tailor an effective intervention programme-

Furthermore, being in the third decade of the HIV and AIDS epidemic, HIV and AIDS epidemiology has shifted over time in response. There is a shift noted in prevalence peak age groups, with an increase in the population aged 25 years and older in the year 2012. The highest age in HIV prevalence has moved from the 25-29 year age group to the 30-34 year age group for females, and from the 30-34 year age group to 35-39 years for males (Shisana et al., 2014). Varying dynamics have been observed to be in operation in each age group. For example, older PLWHA are regarded to be at more significant risk for experiencing HIV and AIDS stigma than the younger age group (LeBlanc, 2011; Sankar, Nevedal, Neufeld, Berry, & Luborsky, 2011). Regardless of the demographic changes (Durvasula, 2014), not much is known about the relationship between age, HIV and AIDS stigma experiences and psychological dysfunctions in South Africa. Establishing such dynamics is therefore important in order to better inform the development of an appropriate intervention programme.

Also, due to the availability of the highly active antiretroviral treatment (HAART), increasingly longer life expectancy is evident among PLWHA, bringing about people with a longer duration of HIV and AIDS diagnosis. HIV and AIDS stigma has been reported to intersect with a longer duration of HIV-positive diagnosis, and psychological dysfunctions among PLWHA (Côté et al., 2015). This pattern of intersection therefore warrants empirical investigation in order to deal with stigma and psychological dysfunctions effectively.

For the development of an efficient HIV and AIDS stigma and psychological dysfunction reduction intervention, the dynamics surrounding the concept of stigma are worth taking cognisance of. The variations in the definition of the concept of stigma have been noted in stigma literature. Link and Phelan (2001) conducted a literature review to establish these variations. They found that the concept of stigma has been mainly used in a vast range of circumstances where in each circumstance stigma is conceptualised differently. This is due to the fact that stigma studies are mostly multidisciplinary with involvement by psychologists, sociologists, anthropologists, political scientists, etc. An overlap in interests has been noted among these disciplines; the difference is however on the focus.

Most researchers define stigma from Goffman's (1963) perspective, who defined stigma as an attribute that is deeply discrediting, that reduces the bearer from a whole and usual person to a tainted discounted one. For example, Jones et al. (1984) defined stigma as an attribute that associates an individual with undesirable stereotypes, which has incorporated Goffman's perspective that stigma should be viewed as a relationship between an attribute and stereotype, which influenced their definition.

However, Link and Phelan (2001) regarded the definition by Jones et al. (1984) as lacking and added the discrimination component to the definition. As a result, Link and Phelan (2001) recommended that stigma be defined in relation to or viewed as a relationship between a set of interrelated concepts. According to Link and Phelan, stigma occurs when some interrelated components converge. Firstly, it is when people differentiate and label individual differences. Secondly, it is when cultural/societal beliefs associate labelled individuals with undesirable characteristics, i.e., to negative stereotyping. Thirdly, labelled individuals are placed in separate categories so as to separate them. Fourthly, labelled individuals experience status loss and discrimination that lead to inequities. Lastly, stigmatisation reduces access to social, economic, and political power that perpetuates the identification of deviance, the construction of stereotypes, the distinction of labelled individuals into different categories, the effecting of condemnation, rejection, exclusion, and discrimination.

The definition of stigma by Link and Phelan (2001) seems to be relatively comprehensive and will be adopted and modified coupled with Goffman's perspective for the current study. The prejudice component, discrediting, discounting and deviance from societal norm will be added to the definition by the researcher.

In this study context, "stigma" is therefore conceptualised as a process whereby elements of stereotyping, prejudice, discrediting, discounting, differentiation, labelling, status loss, and discrimination co-occur in a situation of power with reference to deviance from societal norms.

Variations in the definition of the concept of stigma have not been objected to, due to the complex nature of the phenomenon and the multidisciplinary involvement, as long as the researcher clarifies the operationalisation of the concept (Link & Phelan, 2001).

Stigma has also been recognised to have various types. Literature outlines two types of stigma mechanisms that the stigmatisers are likely to employ. The first one is instrumental stigma, while the other is symbolic stigma (Perloff, 2001). These two types are outlined below with reference to HIV and AIDS. Instrumental stigma involves stigma that arises as a result of perceived threat to an individual's wellbeing that ultimately brings about a negative attitude toward an individual perceived to be the threat (Perloff, 2001). With reference to HIV and AIDS, people avoid, or are hesitant to associate themselves with PLWHA as they are fearful that they will contract the disease.

Symbolic stigma represents cognitive representation of people with certain cognitive schemata. That is, symbolic stigma manifests secondary to the association made between the stigmatised individual with negative attitudes towards the associated stigmatised symbol. For example, in relation to HIV and AIDS, people associate HIV and AIDS with the already prejudiced groups who are associated with moral transgressions and decadence, homosexuality, promiscuity, etc. Thus, the stigmatising attitudes people have towards PLWHA represent the prejudices towards the symbol associated with the HIV and AIDS disease.

Within the two broad stigma mechanisms (instrumental and symbolic), HIV and AIDS stigma is recognised to occur through at least three processes which are: internalised, enacted and perceived stigma. Internalised stigma is conceptualised as a state whereby the negative attributes and beliefs about PLWHA are permitted and accepted internally by the sufferer. Enacted stigma is a state whereby an individual experiences prejudice and/or discrimination arising from others, while perceived stigma is conceptualised as a state whereby PLWHA expect to experience stigma enactments (Rueda et al., 2012). Insight into these various kinds of stigma mechanisms is paramount for this study, in order to provide an effective stigma reduction intervention.

Psychological dysfunction in this study context is conceptualised as the disturbance in the behavioural, affective, somatic, interpersonal, and cognitive functioning of an individual (Pearson et al., 2009).

1.2 Statement of the Problem

Greater experiences of psychological dysfunctions among PLWHA relative to general medical conditions are reported (Yu et al., 2016). The burden of HIV and AIDS stigma is the major source of poor psychological functioning among PLWHA (Chibanda et al., 2014; Obadeji, Ogunlesi, & Adebowale, 2014; Stangl & Grossman, 2012; Yi et al., 2015). Despite awareness of the negative impact of HIV and AIDS stigma on the psychological functioning of PLWHA, little has been done thus far to alleviate this problem. In the absence of interventions that address stigmatisation of PLWHA, these people will continue suffering from psychological problems.

There is therefore a critical need for the development of interventions that seek to reduce stigma and alleviate psychological dysfunctions among PLWHA. Unfortunately, few studies, if any, have been carried out in South Africa in this regard. As a result, psychological dysfunctions continue to have a deleterious impact on the lives of those living with the virus. The dysfunctions compromise the overall well-being of PLWHA with adverse consequences including poor HIV treatment adherence, HIV disease progression, and consequently poor quality of life (Relf et al., 2013).

Owing to poor psychological functioning, PLWHA's ability to effectively adhere to treatment gets compromised, hampering efforts to employ treatment as prevention to curb the scourge of the pandemic. Due to poor compliance to HIV treatment, psychological dysfunctions are as a result responsible for morbidity and mortality among this population (Pitpitan et al., 2012; Uthman, Magidson, Safren, & Nachega, 2014). Furthermore, unaddressed psychological dysfunctions among PLWHA are associated with HIV and AIDS high risk behaviours such as unprotected sexual intercourse, and promiscuous behaviour (Uthman et al., 2014) which further perpetuate the transmission of the virus, creating a vicious cycle. Developing and implementing intervention strategies to counteract the detrimental effects of HIV and AIDS stigma on psychological functioning is therefore a critical component of HIV and AIDS care and prevention.

In spite of the existing psychological dysfunctions indices associated with HIV and AIDS stigma, there is a dearth of research works that seek to empirically develop interventions to alleviate psychological dysfunctions among PLWHA. Hence a gap exists in knowledge.

Most HIV and AIDS stigma reduction interventions were carried out in non-South African contexts (Brown, Macintyre, & Trujillo, 2003); the available studies are mostly limited to the exploration of HIV and AIDS stigma (Demmer, 2011; dos Santos, Kruger, Mellors, Wolvaardt, & Van der Ryst, 2014; Maughan-Brown, 2010; Senyalo et al., 2015) and its influence on psychological functioning (Idemudia & Matemela, 2012), and do not have an intervention component to address the status quo.

There is only one South African HIV and AIDS stigma reduction study (study by Tshabalala & Visser, 2011) which has come to the attention of the researcher with an intervention component that aimed at alleviating psychological dysfunctions among PLWHA. Nonetheless, among the limited HIV and AIDS stigma and psychological dysfunctions reduction intervention studies carried out in other low and middle-income countries, where HIV and AIDS prevalence is high (UNAIDS & WHO, 2013; Sorsdahl et al., 2011), research findings indicate that very little is known about the effectiveness of the interventions, and few have demonstrated efficacy (Sikkema et al., 2015). Thus, the need for effective HIV and AIDS stigma and psychological dysfunctions reduction interventions for PLWHA can therefore not be over-emphasized.

1.3 Aims and Objectives of the Study

The aim of this study is two-fold, for phase I and II

Phase I: For this phase, the aim was to empirically determine HIV and AIDS stigma, and the psychological functioning of PLWHA relative to PLWHPT through baseline assessment.

Phase II: The aim of this phase of the study was to design, implement, and evaluate the efficacy of HIV and AIDS stigma and psychological dysfunctions reduction intervention.

The objectives of the study were:

Phase I

1. To determine stigma experiences and psychological functioning among PLWHA relative to PLWHPT.
2. To determine whether HIV and AIDS stigma, age and duration of diagnosis will predict psychological dysfunctions.

Phase II

3. To design and implement an HIV and AIDS stigma and psychological dysfunctions reduction intervention programme; and to empirically evaluate the efficacy of the designed intervention in reducing HIV and AIDS stigma experiences and psychological dysfunctions among PLWHA.

1.4 Rationale of the Study

The rationale of this study was to determine stigma experiences and psychological functioning among PLWHA, in order to design an intervention programme to address such issues, for better psychological functioning of PLWHA, and consequently better management of the pandemic.

1.5 Scope of the Study

The study was in two phases. Phase I entailed the establishment of baseline data of the variables under investigation i.e., determination of HIV and AIDS stigma, as well as of the psychological functioning among PLWHA through baseline assessment, using the HIV and AIDS stigma scale to determine stigma experiences, and the GHQ 28 to determine psychological functioning. Phase II encompassed development of an intervention programme aimed at reducing stigma and psychological dysfunctions among PLWHA, and then empirically evaluate the efficacy of the developed intervention programme. Informed by the results of the baseline assessment, participants who reported HIV and AIDS stigma experiences and psychological dysfunctions at baseline were exposed to the intervention.

1.6 Significance of the Study

Given the awareness of the adverse impact of HIV and AIDS stigma on the psychological functioning of PLWHA, the intervention designed in this study will benefit PLWHA by empowering them with adaptive skills to cope better with HIV and AIDS stigma experiences and subsequently diminish psychological dysfunctions. The reduced psychological dysfunctions will therefore bring about improved HIV treatment adherence, slow disease progression, and consequently enable better general wellbeing.

Since psychological dysfunctions were found to be associated with risky sexual behaviours (Uthman et al., 2014) that foster HIV transmission, the diminished psychological dysfunctions among PLWHA will consequently relieve society of the burden of HIV and AIDS and stigma by breaking the psychological dysfunctions-induced vicious cycle of HIV spread.

Results of this study will be beneficial to organisations, stakeholders and policy makers involved in planning health care related programmes, for better psychological management of PLWHA. Furthermore, the intervention programme developed in this study will provide a baseline intervention tool that can be replicated for future use or be developed further by researchers interested in HIV and AIDS stigma reduction and better psychological wellbeing of PLWHA. Thus, on a larger scale, the intervention developed in this study will be beneficial in the fight against HIV and AIDS, particularly in South Africa where prevalence rates are the highest in the world (UNAIDS & WHO, 2013).

The study has methodological and theoretical significance as well. As research demonstrate the dearth of effective interventions (Sengupta, Banks, Jonas, Miles, & Smith, 2011, Lodzinski, Motomura, & Schneider, 2012), the current study was therefore designed using a two-in-one study that comprised two phases: phase I and phase II. Phase I study used a cross-sectional design to assess stigma and psychological dysfunctions among the experimental group of PLWHA and the control group of PLWHPT, while phase II focused mainly on designing an intervention programme to alleviate HIV and AIDS stigma and psychological dysfunctions, and empirically evaluated the efficacy of the intervention using a pre-test post-test control group design.

This method is unique in a South African study. Also, this is the first study to use Structural Equation Modelling (SEM) to unravel the relational pathways between HIV and AIDS stigma, age, duration of diagnosis and psychological dysfunctions among PLWHA. This will therefore augment South African literature on HIV and AIDS stigma and psychological functioning. Furthermore, a gap in HIV and AIDS stigma reduction interventions has been identified by Mahajan et al. (2008). From their systematic review of stigma reduction intervention studies, Mahajan et al. (2008) discovered that even in well-designed intervention programmes not much seems to be known about how the reduction in stigma affects the associated health outcome.

As a result, they recommended that studies that aim at designing HIV and AIDS stigma reduction intervention should assess the stigma health related outcome as well, to determine the effectiveness of intervention. Hence, the current study is significant by filling the identified gap, as it assessed psychological dysfunctions as HIV and AIDS stigma health outcome, provided intervention to reduce stigma and improve psychological functioning of PLWHA. The designed SCSi (Stigma Coping Skills Intervention) will contribute and add to theory and practice in the development of effective HIV and AIDS stigma and psychological reduction interventions. Thus, this study is novel in the South African context, particularly in Limpopo Province, contributing to theoretical as well as methodological knowledge.

CHAPTER TWO

2. THEORETICAL FRAMEWORK AND PERSPECTIVES

In this chapter the frameworks and perspectives that seek to provide theoretical insight into the construction, manifestations of HIV and AIDS stigma, and psychological dysfunctions are reviewed. The review is going to assist the researcher in gaining theory-based insight into the dynamics surrounding the construction, manifestation of HIV and AIDS stigma and psychological dysfunctions, which is going to contribute to the development of an effective theory-based HIV and AIDS stigma and psychological dysfunction reduction intervention programme.

2.1 Theoretical Frameworks

Two theoretical frameworks are used in this study, namely: Erving Goffman stigma theory and the HIV stigma model. The frameworks are detailed below.

2.1.1 Erving Goffman Stigma Theory

Understanding of stigma stems from Goffman's work on stigma. Goffman's (1963) theory characterises stigma as a social process dependent on social context, and defines it as an attribute that is deeply discrediting, and an aspect of the self that is socially devalued. Goffman stresses that stigma is a product of social interactions and relationships in which the aspect is constructed as a reflection of its possessor's stained character.

Individuals who are perceived to possess the discreditable attribute are therefore tainted and devalued (Goffman, 1963). Three kinds of stigmatising conditions are proposed by Goffman. The first one he termed tribal identities, which refer to identities such as race, gender, religion, and nationality. The second stigmatising condition he named blemishes of individual character, which encompass such blemishes as having mental illness, having a history of addiction, history of incarceration, or living with HIV and AIDS. Lastly is abominations of the body, which include such bodily conditions as malformations and physical disabilities.

2.1.1.1 Stigma as a Socially Constructed Phenomenon

Stigma is regarded as a global phenomenon; its construction, however, varies across different sociocultural contexts and is shaped by social processes. Stigma is socially constructed and is attributable to cultural, social, historical and situational factors (Goffman, 1963). According to Goffman, stigmatisation results from the type of information that people carry about the day-to-day life of others. These are symbols with which people are constantly judged, embedded along with social information that is used to make such judgements. The judgements can either be positive or negative. Stigma therefore originates from such negative judgements. Goffman emphasizes relationship language when postulating stigma. He posits that an attribute on its own is neither creditable nor discreditable. The deviation from societal norms is the element that leads to the labeling of deviance (Goffman, 1963).

According to Goffman, stigma is a social process wherein language and imagery are used to categorise people. In his classification, individuals are discredited because they possess traits that are deviant from the societal norms. Stigma has been viewed as a subjective and cruel form of social control that produces inequities (Herek, Capitano & Widaman, 2003), located at the centre of societal norms, power and deviance (Parker & Aggleton, 2003, Greeff et al., 2010). According to Goffman, an attribute is constructed as a marker of a tarnished character within the context of social relationships. This marker results in devaluation of the bearer. Ironically, Goffman postulates that the stigmatised individuals tend to accept the norms that stigmatise them by internalising the perception of the stigmatisers.

2.1.1.2 HIV and AIDS and Goffman's Stigma Theorization

With regard to HIV and AIDS, stigma is employed by individuals to define certain attributes of others or self as discreditable or unworthy, resulting in the person stigmatised becoming discounted or tainted. Hence, PLWHA are socially constructed as “others”, who are disgracefully different from and threatening to the general public (Liamputtong et al., 2009). HIV is the attribute that has become a marker of tarnished character. PLWHA are therefore devalued because they bear the discredited mark of HIV. With reference to Goffman's stigmatisation process, people use the type of information they have to judge PLWHA.

As a result, the information (whether myths or facts) people possess about HIV and AIDS, such as its origin, modes of transmission, the manifestation of the disease, is the base on which PLWHA are stigmatised. For example, HIV and AIDS is known to have originated from gays or men who have sex with men, a disease of injecting drug users and a disease of promiscuous individuals who are being punished for their transgressions (Grodensky et al., 2015; Wangen, 2010). It is on the basis of these behaviours that HIV and AIDS stigma manifests, which Goffman conceptualised as a blemish of individual character.

Goffman posits that stigmatization is based on deviance. Thus, PLWHA are perceived to be deviant from the social norms as they bear the tarnished mark of HIV, as well as bodily or physical deviance that manifest with the disease's progression. It is through a process Goffman termed 'passing' that an individual suffering from HIV and AIDS is able to conceal the illness before the illness symptoms manifest visibly and the individual is likely to escape societal stigma based on deviance, but may however still experience internalised stigma due to societal perception of the illness. It is during the process of passing where an individual acquires two identities, which Goffman named personal and social identity. Personal identity is the truthful unconcealed self, while social identity is the identity an individual has tailored to control social information about self. According to Goffman's postulation, possession of these two opposing identities mostly results in incongruity in the life of the stigmatised individual, eventually precipitating psychological dysfunctions.

When HIV and AIDS clinical symptoms start to visibly manifest, mostly in the advanced stages of the illness, in the form of severe weight loss, oral candidiasis, shingles, and Kaposi's sarcoma etc., is what Goffman termed body abomination. It is a phase where passing gets un-instrumental, where it becomes evident that an individual is suffering from HIV and AIDS predisposing them to stigmatisation. Goffman further theorises that tribal stigma is when the stigmatised condition is passed on from individual to individual through family lineages and equally contaminates all members of a family (Goffman, 1963). In relation to HIV and AIDS, tribal stigma can be through mother-to-child-transmission, where the virus is transmitted through such lineages.

The strength of Goffman's theory is that his theorisation gives a perspective into the construction and manifestation of stigma, which is adaptable for any kind of stigma-inducing condition. Hence the current study was able to theorise HIV and AIDS stigma from his framework. Significant to the current study is that it provides a theory-based insight into aspects that predispose PLWHA to stigmatisation, which is beneficial for the intervention of stigma. The theory however does not provide adequate insight into how stigma precipitates psychological outcomes of the stigmatised, hence the HIV stigma model was included.

2.1.2 The HIV Stigma Model

The HIV stigma model was developed by Earnshaw and Chaudoir (2009). The model describes how stigma experiences affect the psychological outcomes of the stigmatised individuals. It provides an understanding of the individual processes of stigmatisation and the pattern in which stigma is experienced by PLWHA.

The model is anchored on the stigma pioneer, Erving Goffman, discussed earlier on, who posits that stigma is a mark of a tarnished, devalued character that is socially constructed through social interactions and/or relations (Goffman, 1963). The model's assumption is that HIV and AIDS is an attribute that is socially devalued; its existence as a socially devalued attribute impacts individuals through its related stigma mechanisms. According to the model, stigma mechanisms characterise the ways in which people react to the knowledge that they either possess the devalued attribute (i.e., HIV-infected) or do not possess the devalued attribute (i.e., HIV-uninfected) (Earnshaw & Chaudoir, 2009).

In HIV-uninfected individuals, the stigma mechanisms characterise the psychological responses to the knowledge that PLWHA carry the label of immorality and character blemishes (e.g., intravenous drug use, risky sexual behaviour, homosexuality), and are perceived as threats to the health of others. For PLWHA, the stigma mechanisms characterise the psychological responses to the knowledge that they are perceived or perceive themselves as individuals with tarnished, devalued attributes who have violated social values. The model further hypothesises that the stigma mechanisms experienced by individuals have an impact on their behavioural and psychological outcomes, depending on the individual's HIV status (Earnshaw & Chaudoir, 2009).

The stigma mechanisms of people who are HIV-uninfected mainly embody efforts to distance themselves from people who are perceived as tainted and blemished, as they perceive themselves as possessing a superior position of power and untainted characters compared to PLWHA.

According to the model, stigma mechanisms are manifested in three predominant ways among HIV-uninfected individuals, which are prejudice, stereotyping, and discrimination towards PLWHA, which represent different behavioural responses that differentially affect outcomes. The endorsement of these mechanisms (prejudice, stereotyping and discrimination) tend to impact the outcomes of HIV-uninfected individuals such that they do not perceive themselves as members of groups that are stereotypically more likely to contract HIV and AIDS (Earnshaw & Chaudoir, 2009).

Through these mechanisms of prejudice, stereotypes, and discrimination, the existence of stigma tends to impact a variety of psychological outcomes for the HIV-infected. Stereotype endorsements subject PLWHA to internalised stigma, where they present with feelings of shame and guilt as they are seen as people who engage in morally questionable behaviours. Discriminatory behaviours by HIV-uninfected individuals are experienced by PLWHA in the form of enacted stigma (e.g., social rejection, or even physical violence) and tend to also elicit perceived stigma where they are less likely to disclose their HIV status because they fear that they will be socially rejected, precipitating psychological dysfunctions (Earnshaw & Chaudoir, 2009; Liamputtong et al., 2009), see Figure 3.

PLWHA know that their HIV status is an extremely socially devalued aspect of the self, hence possess a relative position of subordination compared to individuals who are HIV-uninfected. This knowledge is experienced through at least three important stigma mechanisms which are enacted, perceived, and internalised stigma.

PLWHA who experience stigma via these mechanisms face a variety of often negative psychological outcomes and poorer health, resulting in earlier onset of HIV symptoms as well as rapid progression to AIDS, perpetuating further the prejudice, stereotyping, and discrimination mechanisms (Earnshaw & Chaudoir, 2009), creating a vicious cycle. The current study therefore introduced the intervention component to the model to break the cycle, see Figure 1 below.

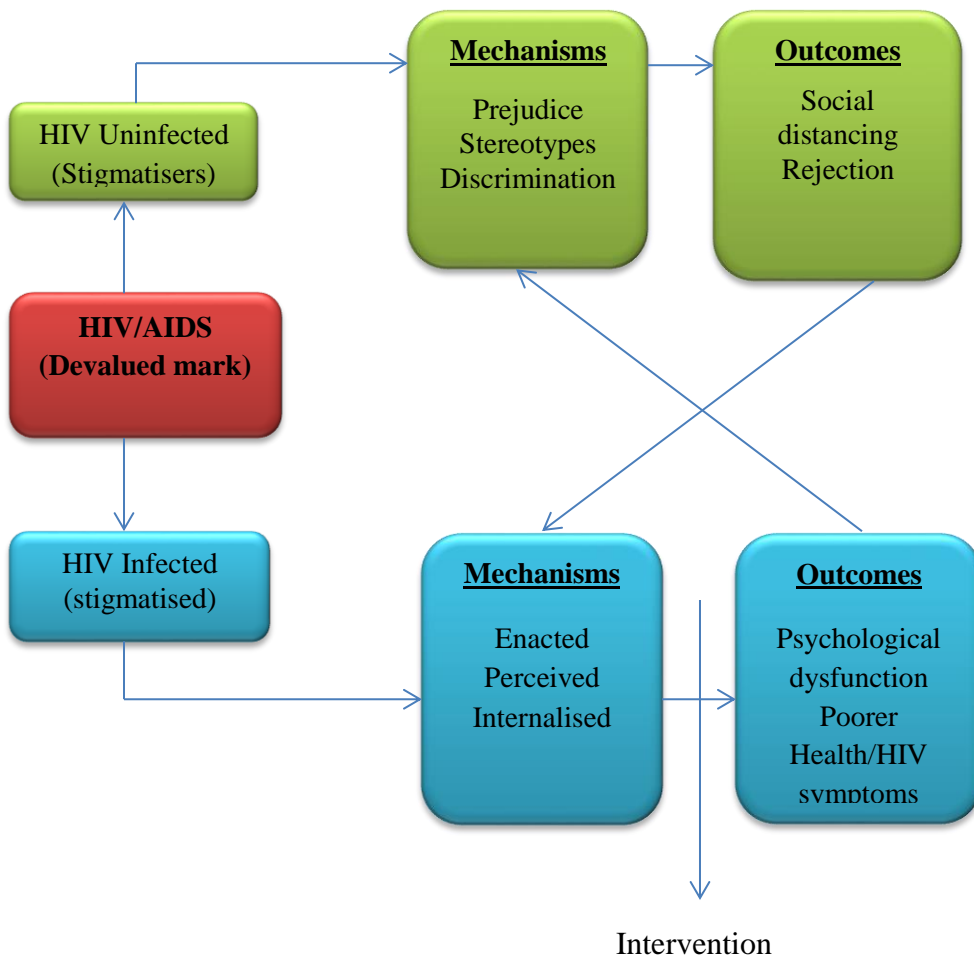


Figure 1: The HIV Stigma Model (Adapted from Earnshaw & Chaudoir, 2009)
 Note: → = means leads to

2.2 Theoretical Perspectives on Stigma

2.2.1 Social Identity Theory

Social identity theory is pioneered by Tajfel (1981). According to social identity theory, individuals perceive themselves and others as group members rather than as unique individuals. An individual's knowledge about one's social group membership and the emotional significance attached to the membership plays a critical role in an individual's self-concept (Ellemers & Haslam, 2012). The theory's assumptions are that group memberships form an integral element of individuals' identities and self-concept. Just as Goffman (1963) alluded that stigma is shaped by social processes, the theory's emphasis is also on social categorisation, social perception and intergroup behaviour. The theory posits that positive group membership has implications on social identity; as a result individuals are striving to establish and maintain such (Tajfel, 1981).

It further postulates that categorisation of self and others into groups is fundamental in the establishment of social identity and self-concept, which is a process based on the emphasis on distinctions between one's own and other groups. The categorisation process yields affective and motivational outcomes. In inter-groups, individuals strive for positive distinctiveness by differentiating their group from the out-group in an evaluative manner. That is, positive affective behaviours are directed towards the in-group, while negative behaviours are directed towards the out-group (Tajfel, 1981).

According to this theory, the positive or desirable in-group characteristics, as opposed to the out-group, are essential in the establishment and maintenance of positive social identity and self-concept.

Individual variation mostly results in perceptual biases and discriminatory behaviour. This variation orientation serves as a function to differentiate the in-group from the out-group. When individuals do not meet social expectations due to undesirable attributes of deviance, they are then devalued and discredited, their sense of identity inside the group is under threat, then stigma manifests. Normality as opposed to deviance is an important construct in social identity and belonging. Deviance threatens societal values, principles which makes stigma probable. Individuals are reduced from acceptable to discounted ones when they fail to conform to expected societal norms due to the attribute they possess. The deviancy then spoils the social identity of the individual, alienating the individual from self as well as from societal acceptance (Tajfel & Turner, 1986).

The perception of PLWHA as dirty, contagious, immoral, self-inflicted sufferers is documented (Liamputtong, 2013). As a result, PLWHA are perceived as the out-group by those who are HIV uninfected (in-group) who perceive themselves as healthy and moral beings. PLWHA (the out-group) are therefore perceived as a threat to the in-group's positive social identity. The deviancies of PLWHA (out-group) elicit negative social emotions from the uninfected group (in-group) which are manifested in the form of stereotypes, prejudice and discriminatory behaviours. As motivation to protect the group's positive social identity, PLWHA are then devalued, derogated and marginalised from the in-group. Essentially, stigmatisation of PLWHA serves a paramount role of group positive social identity protection.

Significance to the current study is that social identity theory provides a theoretical insight into the manifestation of HIV and AIDS stigma in the social group context, i.e. the community an individual belongs to or lives in.

This theory adds value to the current study as it highlights the significance of social group membership and sense of belonging in relation to an individual's social identity, and also assists in understanding the sources of psychological dysfunctions in this particular context. Integral to this theory is that, like any other members of the community, PLWHA's self-concept and individual identity formation is dependent on social group membership. That is, instabilities in group membership will consequently lead to disturbances in identity and self-concept formation with probable psychological dysfunctions. Cognisance of these dynamics will therefore be instrumental in the development of the intervention for this study.

2.2.2 Labelling Theory

Labelling theory is based on a sociological perspective pioneered by Becker (1963). Dating back as early as the 1960s, labelling concept has been operationalised by the medical fraternity to put an emphasis on the symbolic meanings of health and illness; the process has both physical as well as social consequences in terms of deviance. According to Becker, deviance is viewed as contravening norms that the social groups have enforced. Individuals and/or groups are labelled as outsiders by infraction of the societal norms (Becker, 1963).

In agreement with Goffman (1963)'s postulation that stigma is socially constructed, Becker also posits that deviance is not a trait in the individual's behaviour, but rather the interaction between the individual who engages in the act and the societal response to the act. That is, the act that is labelled as deviant from the norm encompasses the negative judgments by others who are in a powerful position to enforce such labels (Becker, 1963).

In relation to the present study, the HIV and AIDS disease label placed on an individual is the label that spoils both the personal and social identity of the bearer. The moment the HIV and AIDS disease label is endorsed, the old identity of the individual gets ripped off and a new one imposed, then HIV and AIDS stigma is produced. The labelled individual mostly internalises the new identity, as Goffman (1963) has postulated, and a new social status is endorsed predisposing them to some psychological problems.

2.2.3 Attribution Theory

Heider is regarded as one of the pioneers of attribution theory (Heider, 1958). Attribution theory is one of the core elements of social-psychological thinking. According to the theory, people make attributions for situations or behaviours that are perceived as unusual, negative, deviant or socially undesirable (Jones & Davis, 1965). Attributional beliefs are defined by Hegarty & Golden (2008) as cognitive schemas about the origins and controllability of a stigmatised trait. Heider (1958) argued that the essential peculiarity people make when trying to explain events in the social world is between personal and impersonal causality. The core assumptions which attribution theory is based on are principles of controllability versus uncontrollability, personal versus impersonal causality, and dispositional inference (Heider, 1958).

Attribution theory posits that an individual's situation or distress that is perceived to originate from uncontrollable causes is likely to elicit positive emotional reactions such as pity, sympathy, empathy, as compared to a situation or distress that is perceived to be of controllable origin, which elicits feelings of hostility. Causal attributions of controllability influence the extent to which stigmatised targets are blamed for their own situations (Heider, 1958).

The causal attributions are categorised into three dimensions, i.e., internality, stability, and controllability. The internality dimension is further subdivided into two: internal and external factors. With the internal factors, the theory postulates that an individual mostly attributes failures to external factors, whereas the observer attributes those to the internal factors. The second dimension of causal attributions is stability, that is, the causal factors are perceived as either stable/permanent or unstable. The third dimension is controllability which refers to the perception of whether the situation is within or beyond the control of the individual. When the situation is perceived to be within the control of the individual, then internal factors are considered to be the cause of the situation, while external factors are perceived to be uncontrollable by the attributer (Heider, 1958).

Attributions are made based on the information attributers have about the situation. That is, the information the attributer has influences the interpretation of the situation. According to this theory, the causal attributions are therefore precursors of prejudice, stereotype and stigma. An individual's situation where causal attributions of controllability are tied to the stigmatised individual, tend to elicit greater prejudice towards that individual (Heider, 1958) (see Figure 2).

Applicability of the theory to the present study is that PLWHAs' infection is mostly attributed to internal, personal and controllability causality which is inferred from their perceived sinful, evil and immoral characters, eliciting prejudice and discriminatory behaviours against them. These negative affective reactions result from the cognitive connections to the perceived causes of HIV and AIDS. That is, HIV and AIDS is primarily perceived to emanate from internal, personal, morally wrong controllable acts such as homosexuality, promiscuous sex, and drug use, etc. These cognitive connections and the attributions made about PLWHA trigger as a result different negative affective reactions, then stigma manifests resulting in poor psychological functioning. The theory adds theoretical value to this study, as insight into how attributions are constructed will be helpful when dealing with HIV and AIDS stigmatised individuals.

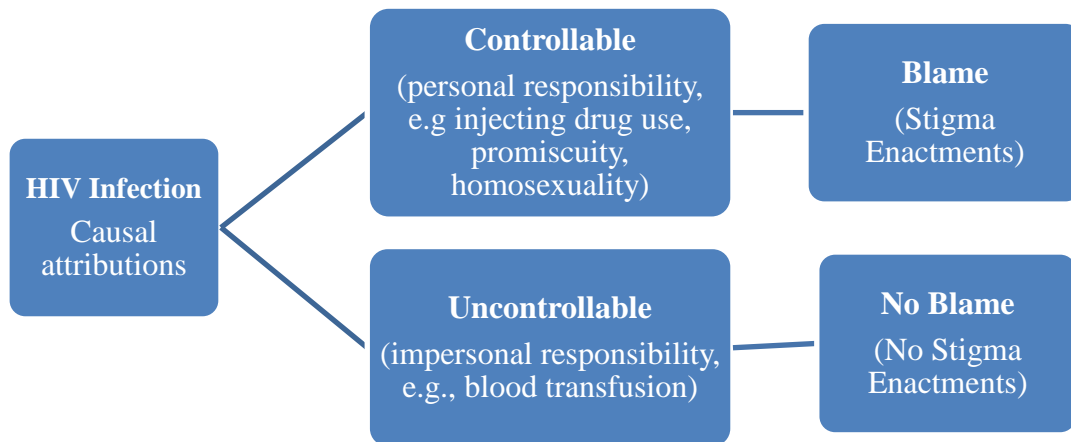


Figure 2: Causal Attributions Predicting HIV and AIDS Stigma

2.2.4 The Disease Avoidance Stigmatisation Model

The disease avoidance stigmatisation model developed by Oaten, Stevenson and Case (2011) is based on two assumptions. The first assumption postulates that species with potentially infectious diseases are avoided. The second assumption postulates that species with more observable disease symptoms are severely stigmatised. The model posits that avoidance is based on perceptions that individuals with ill-health indicators as well as labelled carriers of infectious diseases are avoided. An uncommon feature or sign may be associated or attributed to presence of infectious disease, leading to avoidance of the individual (Oaten et al., 2011). According to this model, individuals as part of the species are evaluated using disease as a basis. The disease avoidance manifests as a function of four components that are interrelated, which are: disgust and contamination; deviance detection; cognitions and labelling, and evaluation and action (Oaten et al., 2011).

a) Disgust and contamination

This component is reflexive and emotive with an output of feelings of disgust and consequential contamination. According to this module, the primary ill-health related sign evokes feelings of disgust, which lead individuals to avoid probable contamination sources. Most disease avoidant behaviours are often reflexive in nature. Disgust is experienced as a feeling of revulsion, occasionally accompanied by nausea. Disgust is further attested to be orally based revulsion towards an offensive stimulus (Rozin, Haidt, & McCauley, 2000). Consequently, the individual will avoid the disgust-eliciting stimulus (Oaten et al., 2011).

b) Deviance Detection

In this component, individuals are categorised based on the abnormality detected in their body which are cues for a disease. Such abnormalities are even more attention-catching if localised in the body parts where they are visible or unable to be concealed, resulting in avoidant behaviour (Oaten et al., 2011).

c) Cognitive Contamination and Labelling

The label learned about the meaning of the disease is likely to elicit the disgust and fear of contamination. The disgust is primarily not elicited by the label of the disease itself, but the knowledge associated with the disease as well as imaginary images constructed with regard to the disease, through associative learning. It is a cognitive process whereby cognitive illness representations are disgust-evoking in relation to the illness label. Labelling in this case is demonstrating how individuals can be stigmatised from the disease avoidance perspective. Cognitive contamination entails the knowledge and beliefs about a particular disease and the knowledge about the consequences of being infected with that particular illness (Oaten et al., 2011). Key here is the fear that is based on the knowledge and understanding of threat of contamination.

d) Evaluation and Action

This component involves the evaluation of disgust, cognitive contamination and detection of non-conforming body patterns or behaviours. Action may be tremendously driven by disgust, if there is knowledge that an individual has been in contact with a disease cue; this may then bring cognitive imageries of the disgust cue whenever the contaminated individual is perceived.

This may result in long-lasting or perpetual contamination even for a long time after the physical trace has been lost (Oaten et al., 2011). The phenomenon has, for example, been revealed by laboratory studies where participants demonstrated reluctance to wear a decontaminated jersey worn by a person reported to have HIV and AIDS (Rozin, Markwith, & Nemeroff, 1992).

Understanding HIV and AIDS stigmatisation from the disease avoidance model perspective, any indication of deviant bodily signs and symptoms that an individual is suffering from HIV and AIDS evokes feelings of disgust and avoidance of the individual. For PLWHA, the body atypicality symptoms are cues such as severe body weight loss, skin conditions such as Kaposi's sarcoma, etc. Therefore, the HIV and AIDS label and the knowledge associated with the label triggers unpleasant cognitive representation of the illness, eliciting feelings of disgust, fear of contamination and avoidance. The knowledge and cognitions that people have about HIV that it is incurable, deadly, and infectious perpetuates stigmatisation of PLWHA, especially enacted HIV and AIDS stigma. Also, the association made between e.g. homosexuality, injecting drug users, promiscuity and the AIDS epidemic are aspects that perpetuate such stigmatisation and psychological dysfunctions among this population. As a result, just the mention of a disease label HIV and AIDS is sufficient to trigger avoidance of PLWHA.

2.2.5 The Magical Law of Contagion

The assumption of the magical law of contagion is that individuals obey some primitive belief that when two objects come into contact, they pass properties to each other and continue to influence each other from that point (Rozin et al., 1992).

The disease that is viewed as deadly evokes feelings of fear of infection, thus bringing about stigmatising behaviour. With reference to HIV and AIDS stigma, people resort to some developed cognitive illness schemas that experts and scientists might not have discovered all the possible HIV transmission routes. As a result, they become cautious in the form of discriminatory behaviour so as not to contract the virus by routes that have not already been discovered manifested as stigma enactments. The schemas are however not constructed based on biomedical facts, but are cognitively constructed with the influence of socio-cultural belief systems and myths surrounding HIV and AIDS (Rozin et al., 1992).

The strength of this model and its relevance to the current study is that it provides a perspective which helps in understanding the source of the persistent HIV and AIDS stigma, particularly enacted stigma, which seems not to respond to the awareness and educational HIV and AIDS campaigns that are being provided (Wong, 2013). For example, it helps explain why people continue marginalising and avoiding contacts or interactions with PLWHA despite adequate knowledge they possess that HIV is not transmittable through such interactions. Understanding of these cognitive schemas is therefore vital for this study for the development of an effective HIV and AIDS stigma and psychological dysfunction reduction intervention programme.

2.3 Summary of the Theoretical Framework and Perspectives

The theoretical frameworks reviewed emphasise deviance, personal responsibility/blameworthiness, fear of contagion and death, as the basis for stigmatisation. Almost all theories and models are anchored on Goffman's conceptualisation of stigma, and demonstrate commonality with regard to elucidation of the manifestation of HIV and AIDS stigma and subsequent psychological dysfunctions.

The insight deduced from the theoretical frameworks posits that stigma manifests as a function of deviance from normality that is socially constructed. The deviance can be actual, perceived or cognitively constructed. The essence of the propositions is that HIV or AIDS is stigmatised predominantly on the basis of deviance of the disease bearer from societal norms in terms of moral contravention and physical/health state. The frameworks further assert that stigmatisation and the constructed negative cognitive schemas around HIV and AIDS impact PLWHA negatively resulting in psychological dysfunctions among this population. Other than pioneering HIV and AIDS stigma enactments, the constructed negative schemas on which basis HIV and AIDS are stigmatised also influence PLWHA's perception about self and the community they live in, fostering self-blame resulting in internalised and perceived HIV and AIDS stigma with consequential psychological dysfunctions.

Also, the nature and course of the HIV and AIDS disease brings about the reality of impermanence and fear of death, further predisposing PLWHA to psychological dysfunctions. The perspective unravelled is essential in gaining insight into the dynamics of HIV and AIDS stigma in relation to the construction, sources and manifestation thereof.

As a result, it is expected that PLWHA will experience more stigma and consequently report poorer psychological functioning than those who are not infected; in this study context, PLWHPT.

2.4 Theoretical Perspectives on Psychological Functioning

2.4.1 Cognitive Behavioural Therapy (CBT)

The Cognitive Behavioural Therapy (CBT) approach is featured by proponents such as Albert Ellis's Rational Emotive Behavioural Therapy (REBT), and Aaron Beck's Cognitive Therapy (CT). CBT incorporates cognitive as well as behavioural components. CBT is largely based on the assumption that a reorganisation of an individual's self-statements will bring about corresponding reorganisation of the individual's behaviour (Corey, 2009). REBT is one of the commonly recognised CBT approaches. Like other cognitively orientated approaches, it emphasises cognitions, judgements, decisions, analysis and action. REBT is based on the basic assumption that individuals contribute to their own psychological dysfunctions by the manner in which they interpret events and situations. That is, individuals are not distressed by the events, but by the perception they have of them. As a result, people's emotions stem primarily from their own beliefs, evaluations, interpretations and reactions to life events (Corey, 2009).

Ellis posits that individuals do not need to be accepted and loved, even though this may be highly anticipated and desired. The REBT is instrumental in assisting individuals how not to feel depressed even when they are unloved and rejected by significant others.

For example, in the study context, when PLWHA are discriminated against due to their HIV positive status, REBT assists in overcoming feelings of depression, anxiety, hurt, hatred and loss of self-worth. Ellis further postulates that individuals predispose themselves to psychological dysfunctions by having dogmatic absolutists such as the “musts” and the “shoulds” (Corey, 2009). For example, in relation to the present study, “other people must treat me considerately and fairly regardless of my HIV positive status; if not I can’t stand it”, “I must be accepted”.

The REBT is centred on the A-B-C-D-E-F model in understanding individuals’ feelings, thoughts, events, behaviour and how to assist such individuals. The (A) is the activating event, which is the triggering factor that triggers subsequent cognitive processes as well as behavioural cues. The (B) is beliefs that individuals hold in relation to the event, and (C) is the behavioural and emotional consequences that are based on the beliefs about the event. Ellis further posits that individuals have the capacity to significantly change their cognitions, emotions and behaviour. As a result, the (D) component was added to the model. The (D) entails disputing the irrational thoughts individuals have that cause psychological dysfunction (C). With the (D), individuals learn how to detect, debate and discriminate self-defeating irrational thoughts. When the irrational thoughts are successfully disputed, it brings about the (E), which is the effective philosophy (Corey, 2009). The effective philosophy entails replacing maladaptive cognitions with adaptive ones. With effective philosophy in place, individuals attain revised feelings, which bring about improved feelings, the (F) of the model (Corey, 2009).

The relevance of the REBT's A-B-C-D-E-F model to the present study is that it provides a theoretical insight into the precipitation of psychological dysfunctions, and how to deal with them. In relation to the present study, HIV and AIDS stigma can be regarded as the activating event (A). The (B) is the distorted beliefs PLWHA have constructed in relation to HIV and AIDS stigma, that is, believing and internalising the stereotypes imposed upon them by the stigmatisers, as Goffman (1963) has postulated. For example, "I am immoral, blameworthy for my HIV positive status". The (C) is the emotional consequence that manifests as a result of the distorted beliefs (B) that PLWHA have constructed. That is, PLWHA develop psychological dysfunctions such as depression or anxiety, following the distorted beliefs about themselves or beliefs others have about them with regard to their HIV and AIDS status.

With the lens of this model, during the intervention, the irrational thoughts are challenged and disputed (D), for example, "I am not immoral", "I am not blameworthy". Disputing and challenging irrational thoughts assist PLWHA to develop an effective philosophy (E), for example, "I don't need to be accepted by others to feel better". As a result, the effective philosophy brings about improved feelings (F), and subsequently the remission of psychological dysfunctions. Below is the summary of the model in a diagram form (see Figure 3) depicting the manifestation of the psychological dysfunctions and the intervention to alleviate such dysfunctions in relation to HIV and AIDS stigma.

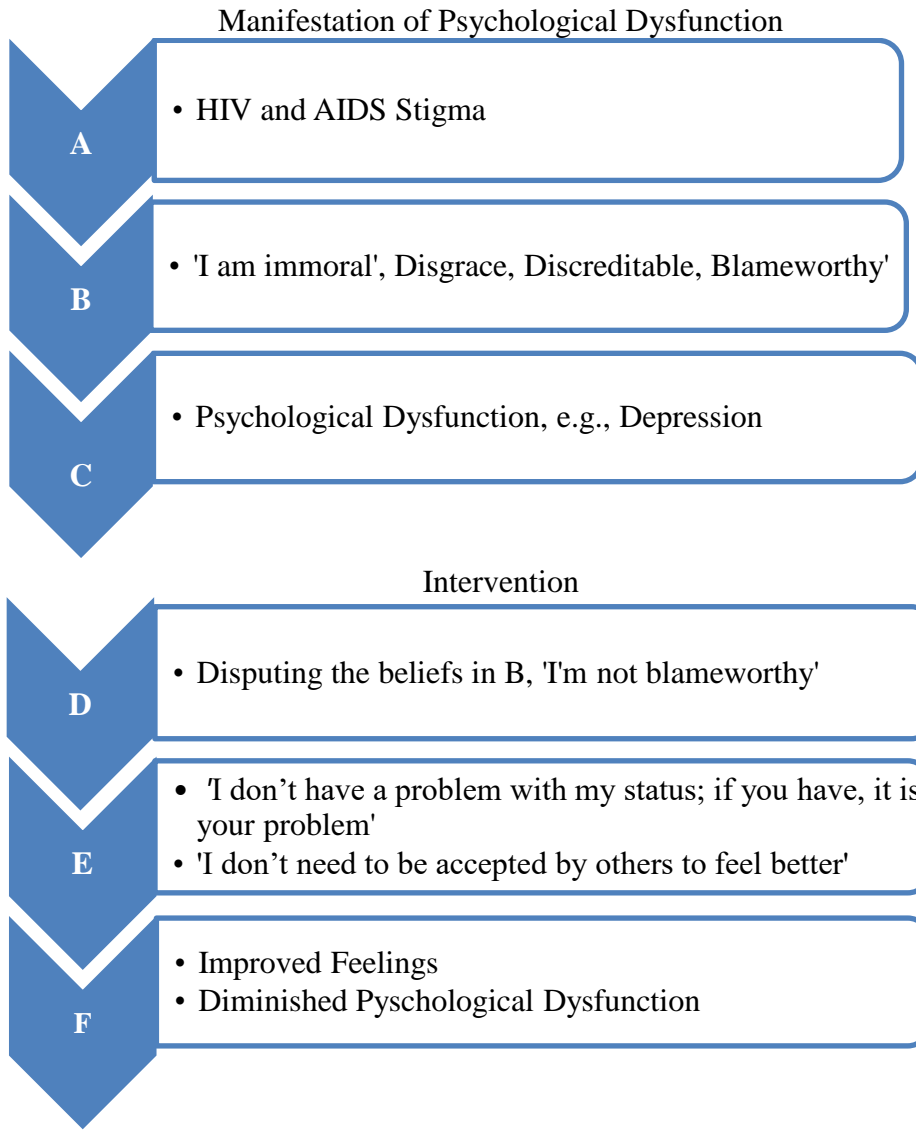


Figure 3: The REBT's A-B-C-D-E-F Model Representation of the Manifestation of Psychological Distress Secondary to HIV and AIDS Stigma and Intervention.

A = Activating Event, **B** = Believing, **C** = Emotional Consequence,
D = Disputing, **E** = Effective Philosophy, **F** = Feeling

Note: the statements are adapted from Ellis's REBT and modified to suit the study context.

2.4.2 Terror Management Theory

Terror Management Theory is anchored upon the work of a cultural anthropologist Ernest Becker. The theory is a social psychological theory that draws from existential, psychodynamic, and evolutionary perspectives to understand the strong influence that distress about mortality can have on human sense of self and social behaviour (Arndt & Vess, 2008). With his existential view of death, Becker postulates that the human drive to stay alive versus the consciousness of the inevitability of death has the power to produce intense fear of death (Becker, 1973). The premise of terror management theory is that human beings are distinctive because of awareness of their own mortality, and that death can often occur prematurely and unexpectedly. This awareness of one's own mortality often creates an overwhelming and incapacitating existential anxiety (Becker, 1973).

Attempts to cope with one's impermanence are regarded to be at the root of human social behaviour (Shaver & Mikulincer, 2012). Individuals are likely to experience anxiety when their understanding of the worldview of impermanence is threatened (Greenberg, 2012; Hayes, Schimel, Arndt, & Faucher, 2010), precipitating psychological dysfunction. The theory postulates that individuals guard against this existential anxiety by conforming to a cultural or societal worldview that enforces order and meaning. The deviance or perceptions thereof are adequate to arouse existential anxiety; however, it is especially likely to occur when such deviances generate concerns in people about their own vulnerability, such as when faced with a terminal disease (Solomon, Greenberg & Pyszczynski, 1991) such as HIV and AIDS. The experience of existential anxiety therefore leads to poor psychological functioning for the disease bearer, particularly anxiety.

In relation to the present study, HIV and AIDS is perceived as a deadly disease and has been perceived as fatal since its emergence up to now. As a result, PLWHA are confronted with existential anxiety, and death becomes probable, leading to psychological dysfunction. Death anxiety is regarded to be basic in the development and maintenance of numerous psychological conditions (Iverach, Menzies & Menzies, 2014). An individual's assumption of personal immortality therefore gets shattered, precipitating psychological dysfunction or poor mental health. This theory therefore provides a perspective from an existential point of view about the development of psychological dysfunctions secondary to HIV and AIDS positive status and its subsequent stigma, which will be instrumental during the design of the intervention programme to alleviate such dysfunctions.

2.4.3 Group Psychotherapy

The intervention in this study employed a group psychotherapy approach. Group psychotherapy is a form of psychological intervention where a small group (6-12 members) of individuals meet regularly to deal with their personal distress that is facilitated by a qualified practitioner. According to Yalom (1995), effective group therapy can assist in providing support to group members, skills building, enhanced sense of self-responsibility and assisting group members to cope with personal distress. This can be done in a variety of manners, through, for example, counselling, skills training that can be through presentation of educational materials, and role plays. Yalom's group therapy model was adopted for the intervention of the current study. The model is based on principles which have a curative effect on group members; the principles are outlined below.

Group cohesion: Being a member of a group often instils a sense of belonging in the participant through cohesiveness and joint decision-making. The cohesion has the ability to motivate members to remain in group therapy. The positive relationship between cohesion, particularly member-to-member, and positive therapy outcomes has been documented (Yalom, 1995). In relation to the current study, a sense of belonging has a curative effect on the participants as these individuals are discriminated against and socially excluded due to their HIV status; the group therefore gives them a sense of belonging and acceptance.

Universality: Group therapy helps participants realise that their situations are not unique; others have similar experiences. This helps in alleviating feelings of being alone, fears and anxieties surrounding their situations (Yalom, 1995). Thus, a group will offer members an opportunity to realise that their experience of being stigmatised is not unique, that stigma is a common problem among PLWHA, thus helping in lessening the psychological dysfunctions.

Catharsis: One of the psychologically vital aspects is that participants are afforded a platform to express distressing feelings and gain relief from having expressed those feelings, bringing about a sense of emotional easiness (Yalom, 1995). Given the fact that a group provides a sense of belonging and universality, participants are able to freely express their emotions and feelings without fear of prejudice.

Instillation of Hope: Participants realise their commonalities in terms of their challenging experiences with other group members; they often find hope, hence stay focused on and anticipate resolution of their challenges (Yalom, 1995).

Imparting of Information: Participants get a chance to learn and gain information about their situation and also learn from the group how best to deal with their challenges (Yalom, 1995). That is, the group gets an opportunity for vicarious learning from fellow group members on coping and other skills to deal with HIV and AIDS stigma.

The Corrective Recapitulation of the Primary Family Group: The cohesion and homogeneity of the group members make them feel that they are a family, which enhances their strength to deal with their issues in a collective manner (Yalom, 1995). The fact that all group members are PLWHA (homogeneous) who have a universal problem of stigma, gives them courage to collectively come up with strategies to tackle HIV and AIDS stigma.

Development of Socialising Techniques: Participants get the opportunity to learn that the group is a place to be with homogeneous others, listen, talk to others, and learn about others' approaches to challenges (Yalom, 1995) related to HIV and AIDS stigma.

Imitative behaviour: Group members get the opportunity to copy good behaviours from others, try them and adopt them when they are proven helpful to them (Yalom, 1995).

Interpersonal learning: Group members get the opportunity to learn good interpersonal skills and therefore learn to replace negative patterns with positive ones (Yalom, 1995).

Altruism/Selflessness/Humanity: Participants learn the significance of member collaboration in helping each other and get the opportunity to develop appropriate boundaries dealing with their situation better, i.e. give and receive scenario (Yalom, 1995).

2.5 Operational Definition of Terms

In this study:

HIV and AIDS Stigma is defined as process when elements of stereotyping, prejudice, discrediting, discounting, differentiation, labelling, status loss, and discrimination interrelately occur with reference to deviance from societal norms. In this study, it is determined on scores obtained on the HIV and AIDS stigma scale that comprised three subscales (internalised, perceived and enacted stigma), with high scores indicating high stigma experience.

Psychological dysfunction is defined as a disturbance in the behavioural, affective, somatic, interpersonal, and cognitive functioning of an individual (Pearson et al., 2009). This is measured on scores obtained on the GHQ 28 scale that consists of four subscales, with a high score indicating high psychological dysfunction.

Age refers to chronological age of an individual in years.

Duration of diagnosis refers to the length of time in years that an individual has been living with the diagnosis. Short duration is regarded as a period of one year or less, moderate duration as a period between two to four years and long duration as a period more than five years.

Psychological intervention refers to a therapeutic activity facilitated by a qualified clinical psychologist that is aimed at alleviating psychological dysfunctions through modification of thoughts, feelings and behaviour.

CHAPTER THREE

3. REVIEW OF EMPIRICAL STUDIES

This chapter contains the review of the relevant empirical studies in relation to variables under investigation. The variables include three independent variables namely: HIV and AIDS stigma, age, and duration of diagnosis; and one dependent variable, namely psychological functioning.

3.1 Understanding Stigmatisation Process

For the development of an effective stigma reduction programme, understanding of the process of stigmatisation is vital. Stigmatisation occurs when individuals are treated unfairly and unjustly due to the perception that the individual is deviant from others (Deng, Li, Sringeriyuang, & Zhang, 2007). According to Link and Phelan (2001), stigma occurs when five components which are intertwined converge, which are: the differentiation and labelling of human differences; association of human differences with negative attributes, separating the “us” from the “them”; status loss and discrimination; progression to limited access to social, economic and political power that enhances disparities and rejection.

The first component, differentiation and labelling of human differences, involves social selection of human differences that are identified and differentiated based on social norms of deviance, then labelled as deviant. The social selection of human differences is centred on noting attributes that are deviant from society or sociocultural norms (Link & Phelan, 2001). In relation to HIV and AIDS stigma, PLWHA are differentiated and labelled based on the deviant ‘HIV’ mark they possess that is divergent from sociocultural norms.

The second component, associating human differences with negative attributes, occurs when stereotypes are linked to the labelled differences (Link & Phelan, 2001). That is, people are undesirably labelled or negatively stereotyped with reference to societal norms or dominant cultural beliefs. Thus PLWHA's societal deviance is inferred to the individual's attribute, which is viewed as negative, e.g., sexual immorality such as homosexuality etc.

Separating the "us" from the "them" component, which is the third component transpires when people are categorically placed to achieve separation; the stigmatisers and the stigmatised. The separation is driven by the kinds of labels given to the "them", whereby the "them" or the stigmatised are perceived to be the nature of the labels they carry (Link & Phelan, 2001). For example, with reference to HIV and AIDS, it is when PLWHA are differentiated and labelled as immoral.

The fourth component is status loss and discrimination, this is the domain in which the labelling induces status loss and stigmatisation resulting in downward placement of the stigmatised in a status hierarchy (Link & Phelan, 2001). That is, the attribute that brought the label reduces the status of the label bearer in the eyes of the labeller resulting in stigmatization. In relation to HIV and AIDS, PLWHA are therefore stripped of their social status, put down, and the stigmatisers consequently adopt an upward position (Link & Phelan, 2014) in the societal hierarchy. Lastly, the progression to limited access to social, economic and political power component occurs when people are disadvantaged to fair access and involvement in social, economic and political activities due to the deviant attribute they possess (Link & Phelan, 2001).

Relating to HIV and AIDS, PLWHA are consequently denied access to social, economic and political engagement, which enhances disparities and rejection due to the attribute of deviance (HIV positive status) they possess, which is perceived to have been acquired through practices that are morally wrong. PLWHA are therefore socially constructed as the “others” who are disgracefully deviant from and threatening to the well-being of others; as a result, HIV and AIDS stigma manifests.

3.2 HIV and AIDS Stigma Experiences in South Africa

To effectively deal with HIV and AIDS stigma, it is important to learn about trends, what has already been done, and what still needs to be done in South Africa with regard to the status quo. This will provide awareness of the past, current and emerging HIV and AIDS stigma experiences lived by PLWHA in South Africa. As a result, South African studies on HIV and AIDS stigma will be reviewed.

Some few years ago, studies have been reporting PLWHA as experiencing HIV and AIDS stigma in South Africa. For example, the results of a survey conducted by Simbayi et al. (2007) indicated experiences of HIV and AIDS stigma among their participants, with 40% of South African PLWHA reporting experiences of stigmatisation as a result of their HIV positive status; one in five had lost a place to stay or a job because of their HIV status. Research findings are still showing stigma experiences in South Africa. For example, findings by Chibanda, et al. (2014) also indicated high levels of enacted stigmatising behaviours towards PLWHA.

Furthermore, another recent finding of an exploratory descriptive study conducted by Senyalo et al. (2015) in Soshanguve, one of South Africa's townships, indicated that PLWHA in South Africa still encounter HIV and AIDS stigma in the communities they live in. Experiences of PLWHA include being rejected by their family members, struggling to find a job or get a reconstruction and development programme (RDP) house, owing to their positive HIV and AIDS status, were reported. Stigmatising experiences were also reported even at the structural level, whereby participants were discriminated against by health care providers at some hospitals as well as prisons through service denial, and PLWHA's job contracts being terminated as a result of their HIV and AIDS status. An incident of doctors and nurses having had to double their gloves when performing child-birth operations in one of the hospitals on one participant was reported (Senyalo et al., 2015), which indicates the extent of the problem.

In addition, in same study, Senyalo et al. (2015) found that some community members asserted stigmatising tendencies, whereby some communities reported that they will never sleep next to or share a bed with PLWHA. Degrading and name calling of PLWHA was also found to be pervasive, names such as "z3" (AIDS) and "sephamola" (grabbed by HIV and AIDS) were commonly used to derogate PLWHA. Similarly, Rispel, Cloete, and Metcalf (2015) also found name calling and labelling, rumours and gossips, and other obvious discrimination by family members, friends, and broader societal discrimination were reported by about 43% participants in their study.

In another exploratory survey measuring HIV and AIDS stigma experienced by PLWHA in four provinces of South Africa (Limpopo, Gauteng, Mpumalanga, and North West,) found that self-blame was reportedly experienced more often, resulting in internalised stigma. Owing to HIV and AIDS stigma, it was found that most participants (60.1%) decided not to have more children, 57% decided not to get married or not to have sex, 30.9% isolated themselves from their friends and family or from social gatherings, 28.8% avoided going to clinics or hospitals when required, about 10% had stopped working, 7.2% had not applied for jobs or promotions for which they felt qualified, and 4.4% pulled out from education and training (dos Santos et al., 2014). These findings clearly indicate that HIV and AIDS stigma is still persistent in South African communities and continues to impact lives of PLWHA negatively.

Furthermore, significantly high levels of HIV and AIDS stigma in rural communities in Gauteng province were noted relative to other provinces. This was revealed by findings of a study conducted by Visser, Makin, Vandormael, Sikkema and Forsyth (2009) using a two-way analysis of variance between Limpopo and Gauteng, the poorest and the wealthiest provinces. The reason for the pattern for this finding was not empirically established. The comparison was reportedly only between the two provinces due to insufficient participants in other provinces included in the study to allow statistically sound comparisons. The results showed that perceived HIV and AIDS stigma was prominent over other stigma dimensions in the communities of Atteridgeville and Mamelodi townships in the Tshwane Metropolitan area, where PLWHA were presumed to be treated with less compassion and consideration.

With regard to enacted HIV and AIDS stigma, participants were asked to describe incidents of discrimination that they had either witnessed or experienced. 78% of the participants reported such incidents, with 38.1% of subtle discrimination such as gossip, 20.7% of PLWHA not being treated with respect, and 18.2% keeping a distance from PLWHA, were the most shared forms of stigmatisation. Explicit discrimination was less reported, such as attempts to humiliate (11.0%), physical harm (2.3%), neglect of PLWHA (1.2%.) Similarly, gossip and blame were found to be common in findings of a study that examined HIV stigma and discrimination among more than 600 individuals in South Africa, Tanzania, Thailand and Zimbabwe (Maman et al., 2009), making such enactments probably the common forms of stigmatisation of PLWHA.

In further agreement, Maughan-Brown (2010) conducted a survey in Cape Town South Africa, to determine the changing patterns of HIV and AIDS stigma in relation to the three dimensions of HIV and AIDS stigma, i.e., behavioural intentions towards PLWHA, instrumental stigma and symbolic stigma. The survey was carried out among a sample of 1074 young adults aged between 14 and 22 years, in 2003 and 2006 respectively. The survey findings indicated that general stigma increased among the population between the period of 2003 and 2006, and behavioural intentions towards PLWHA got slightly more negative over time, while the overall levels of discriminatory intentions or enacted stigma remained relatively low in this population.

Nonetheless, according to Maughan-Brown, this did not necessarily suggest that enacted stigma towards PLWHA was not a problem or not increasing, as the more subtle manifestations of enacted stigma, such as gossip or hand signals may have still been more prevalent than the obvious and extreme manifestations captured by typical survey questions. For instance, 60% of the participants reported that they had personally heard other people saying offensive things about PLWHA (Maughan-Brown, 2010). Thus, gossip was also prevalent in this population as it was in the above mentioned studies by Maman et al. (2009), and Visser et al. (2009).

In the same survey, age variations in relation to stigmatising attitudes were also explored in the same population. Comparatively, a small variation was noted between the age groups for each dimension of stigma over time. However, the older group were found to experience a significant increase in negative behavioural intentions, and the increase was non-significant for the younger group. The younger group reported somewhat larger increases in both instrumental and symbolic stigma relative to the older group. The increase in stigmatising attitudes in the younger age group was somewhat alarming considering the fact that, according to Maughan-Brown (2010), the participants were in the age group which HIV and AIDS prevention messages intensively targeted during that particular period. This finding therefore signifies the need for interventions beyond prevention messages campaigns. Also, the increases in HIV and AIDS stigma were noted over the same period during which South Africa started rolling out antiretroviral treatment programmes through the public sector, the programme that was initiated in Cape Town in 2001 where the survey was carried out.

This then suggests that HIV and AIDS stigma reduction through these kinds of initiatives is not sufficient to bring about the desired changes.

Findings of the studies reviewed above mainly indicate that HIV and AIDS stigma continues to be prevalent in South African communities, notwithstanding the programmes that are put in place to eradicate the stigma. Thus, other factors that maintain stigma at high levels, such as the psychological factors, need to be looked into and be incorporated in the intervention to eradicate HIV and AIDS stigma.

3.3 HIV and AIDS Stigma and Psychological Dysfunctions Versus Other Chronic Conditions

HIV and AIDS seems to be the supremely stigmatised medical condition globally and viewed more negatively than other chronic physical health problems (Crawford, 1996; Corrigan et al., 2000). Studies carried out across continents have unvaryingly demonstrated that negative views of PLWHA are common over other medical conditions (Greeff et al., 2008; Ndinda, Chimwete, McGrath, & Pool, 2007). This is mostly due to the fact that HIV and AIDS stigmatising beliefs are a result of multiple moral, cultural and social influences including attributions of responsibility for HIV infection (Olalekan, Akintunde, & Olatunji, 2014; Simbayi et al., 2007). However, studies that empirically ascertain this claim in the South African context are scant, hence the present study included PLWHPT. Empirical studies on stigma and hypertension are relatively few, both globally and in South Africa.

Nonetheless, the few available studies were reviewed and the following were noted. Hypertension was found to be stigma-inducing compared to other chronic medical conditions such as diabetes. This is the finding of the study conducted by Adams and Carter (2010), where they investigated factors that are barriers to best outcomes in the management of the two conditions. It was found that stigma led PLWHPT to conceal their illness compared to patients suffering from diabetes (Adams & Carter, 2010). Furthermore, the findings of a study by Roeloffs et al. (2003), where they compared stigma experiences among PLWHPT, diabetes, depression and HIV and AIDS indicated that hypertension was less stigmatised than HIV and AIDS, and HIV and AIDS was relatively more stigmatised. Thus, stigmatising tendencies surrounding hypertension do exist; however, relative to HIV and AIDS, hypertension is less stigmatised.

In the same light, the findings of a study conducted by Mak et al. (2006) compared stigma towards infectious diseases such as severe acute respiratory syndrome (SARS), tuberculosis (TB) and HIV and AIDS. Their aim was to establish which of the three conditions is more stigmatised than the others. Their findings revealed that HIV and AIDS was more highly stigmatised than the two other conditions. Similarly in South Africa, Idemudia and Matamela (2012) found a similar pattern, where they compared the experience of stigma among HIV and AIDS patients, and other chronic illnesses, in their case cancer. HIV and AIDS patients were found to have experienced more stigma than cancer-suffering patients.

Stigma was further investigated in patients suffering from HIV comorbid TB in a study by Deribew et al. (2010). The results of the study revealed that patients as well as their families commonly disclosed illness and/or death to be a result of TB rather than HIV, in order to be protected from HIV and AIDS stigmatisation.

These selective disclosures were found to be based on the social construction and management of unequal stigmatised self-identities, with HIV's causal attribution as more blameworthy than TB or any other medical condition (Deribew et al., 2010). In agreement, Daftary (2012) found that PLWHA concealed their HIV and AIDS illness more than TB, demonstrating the extent of fear of HIV and AIDS stigmatisation.

Notably, the studies reviewed signify HIV and AIDS to be a relatively highly stigmatised chronic medical condition. However, none of these studies had an intervention component to reduce the HIV and AIDS stigma experiences, the gap that the current study seeks to fill.

With regard to the psychological dysfunctions among PLWHA relative to those suffering from other chronic conditions, PLWHA are reported to be disproportionately affected by higher rates of psychological dysfunctions, particularly depression, in comparison with those suffering from other non-communicable diseases (Sherr, Clucas, Harding, Sibley, & Catalan, 2011). Similarly, Idemudia and Matamela (2012) found that anxiety and depression were the predominant psychopathologies suffered by PLWHA compared to cancer patients. Investigating further, they found that perceived HIV and AIDS stigma had a relatively significant effect on depression.

With regard to psychological functioning among PLWHPT, literature is also rather scant. Few studies investigated the psychological functioning of PLWHPT. Nevertheless, according to Hamer, Batty, Stamatakis and Kivimaki (2010) psychological dysfunctions such as depressive symptoms and anxiety are associated with hypertension.

This was revealed in the findings of the study by Hamer et al. (2010) where they compared psychological dysfunctions among patients who were aware and those who were not aware of their hypertension diagnosis. Their results showed that patients who were aware of their diagnosis reported more psychological dysfunctions than those who were not. They attributed this finding to the labelling surrounding the illness. They concluded that labelling people as hypertensive accounted for high levels of psychological dysfunctions. This is consistent with a finding of the study by Pickering (2006), who also found that patients labelled as hypertensive reported poor psychological functioning.

Given findings of the above studies, PLWHA seem to experience more psychological dysfunction relative to individuals suffering from other illnesses. Hypertension studies also indicate that PLWHPT seem to experience stigma-induced psychological dysfunctions as well. However, there is no study brought to the attention of the researcher this far that made a comparison between HIV and AIDS and hypertension in terms of stigma experiences and its subsequent psychological dysfunction. Findings of the present study will therefore contribute to knowledge in the South African literature.

3.4 HIV and AIDS Stigma and Psychological Functioning

There is empirical evidence that suggests that HIV and AIDS stigma contributes disproportionately to psychological wellbeing (Brondolo, Gallo, & Myers, 2009; Logie & Gadalla, 2009, Valdiserri, 2012). Research indicates that PLWHA who experience stigma are susceptible to psychological dysfunctions (Chambers et al., 2015).

In a study conducted among an urban sample of PLWHA by Relf and Rollins (2015), it was found that participants experienced significant levels of HIV and AIDS stigma and poor psychological functioning on a day-to-day basis. High levels of HIV and AIDS stigma were significantly associated with a self-identified need for psychological treatment as well as willingness to take medications for their psychological state.

In agreement, in a study conducted on associations between HIV and AIDS stigma, racial discrimination, and depression, an association between HIV and AIDS stigma and increased levels of depression was revealed (Logie, James, Tharao, & Loutfy, 2013). It was established that PLWHA were disproportionately affected by higher rates of depression. The finding is consistent with the results by Chibanda et al. (2014), where high levels of psychological dysfunctions were reported among PLWHA. However, on the contrary, high general psychological functioning with lower levels of depression and low maladaptive coping strategies were revealed in a subpopulation of gay men. This finding was however attributed to high coping mechanisms and resilience against stigma the same-sex population have already developed in dealing with their sexual orientation (Brennan, Emlet, Brennenstuhl, & Rueda, 2013).

In relation to the stigma dimensions, Kuteesa et al. (2014) found perceived HIV related stigma to be highly associated with psychological distress over other stigma dimensions. A similar finding was noted by Relf and Rollins (2015), where individuals reporting higher levels of HIV and AIDS perceived stigma reported poor quality of life both psychologically and physiologically. In the same light, Igumbor, Stewart and Halzemer (2012) investigated factors influencing quality of life among PLWHA. Perceived HIV and AIDS stigma was found to influence the general quality of life. In further agreement, perceived HIV and AIDS stigma was found to contribute to poor mental health including depression and post-traumatic stress disorder in findings of a study conducted by Bogart et al. (2011).

Exploring further, Herek, Saha, and Burack (2013) conducted a study where they examined how awareness of internalised stigma and negative feelings toward oneself, and shame as a member of a stigmatised group are related to psychological wellbeing. It was found that internalised stigma was significantly correlated with symptoms of depression and anxiety. They further established that internalised stigma mediated the relationship between psychological dysfunction and HIV and AIDS related changes in physical appearance.

Furthermore, findings of a study by Yi et al. (2015), indicate that psychological dysfunction among PLWHA as measured by the GHQ-12 was found to be significantly associated with stigma experiences, with more fear of enactments in the families and communities participants lived in.

In further agreement, in a study conducted by Brener, Callender, Slavin, & de Wit (2013), where they determined the role of visible HIV and AIDS symptoms on experiences of HIV stigma among PLWHA, a positive relationship was found between HIV signs and symptoms with psychological dysfunctions. That is, the more visible signs of symptoms of HIV the participants had, the more psychological problems were experienced.

Findings of all the studies reviewed above, except for the study by Brennan et al. (2013) among gay men, conclude that PLWHA experience psychological dysfunctions. Also, none of the studies had an intervention component to alleviate the identified problem.

3.5 Age and HIV and AIDS Stigma

When HIV and AIDS first emerged it was perceived to be an illness of people of younger age (Riley, 1989). Due to changing patterns of HIV and AIDS progression, cases of older people living with HIV and AIDS are now prominent as a result of improved availability of antiretroviral therapy which prolong survival and aging of long term survivors as never before (Côté et al., 2015). The proportion of older PLWHA has increased in all regions around the world since 2007 according to the UNAIDS (UNAIDS, 2013). Approximately 30% of PLWHA are aged 50 years and over globally, with North America having the highest percentages of adults 50 years and over living with HIV. In South Africa, the prevalence was 13% of PLWHA aged 50 years and above, with a prevalence of 7.3% in Limpopo Province in 2012 (UNAIDS, 2013).

HIV and AIDS stigma has been empirically documented in older populations (Emlet, 2006; Emlet, 2007; Foster & Gaskins, 2009; Haile, Padilla, & Parker, 2011; UNAIDS, 2013; Emlet et al., 2015). Research demonstrates that older PLWHA are more vulnerable to experiences of HIV and AIDS stigma (LeBlanc, 2011; Sankar et al., 2011). Results of studies investigating the relationship between age and HIV and AIDS stigma are however inconsistent. Findings of studies by Relf and Rollins (2015), Talley and Bettencourt (2010), and Bogart et al. (2008) found that age was associated with high levels of HIV and AIDS stigma.

Additionally, coupled with high levels of HIV and AIDS stigma, older PLWHA were found to also suffer from stigma of various forms, a process called layering (Emlet, 2006; Kuteesa et al., 2014 Reidpath & Chan, 2005). This was attributed to be as a result of double stigma of being HIV positive, coupled with age-related stigma conceptualised as ageist stigma (Cahill & Valadéz, 2013). Studies conducted by Cahill and Valadéz (2013), and Logie and Gadalla (2009) found that older individuals living with HIV and AIDS often experience layered stigma associated with ageism among other factors. In agreement, Grodensky et al. (2015) found that older women living with HIV and AIDS experienced more stigma-related challenges associated with ageism, where participants perceived their HIV-positive serostatus as more shameful at their older age, resulting in isolation and inhibition to seek care and support, predisposing them to psychological dysfunction.

In partial agreement, Emlet et al. (2015) in their study in which they investigated whether HIV and AIDS stigma increases or decreases with age, they found that PLWHA who were older than 55 years had significantly less global and internalised than enacted stigma than those that were younger than 40 years.

Furthermore, Emler et al. (2015) investigated the relationship and interaction between age, HIV and AIDS stigma and psychological dysfunctions, particularly depression experiences. They established that the adverse age-related experiences climax by the age of 50 among individuals who are not depressed. Experiences of such nature included cognitive aspects such as fears of getting old or becoming ill and social aspects such as separation from sexual partners, family stress and career transitions. These aspects were found to influence how HIV and AIDS stigma is anticipated within this older population. Even when those with depression may have had common age-related experiences, these were found to be hidden by the adverse consequences of the stigma of depression itself. Their findings reveal that older age is associated with higher levels of enacted than internalised HIV and AIDS stigma.

Contrary to studies that found a positive association between HIV and AIDS stigma and increased age, a meta-analysis of research on PLWHA found a negative relationship between age and stigma, with younger individuals reporting more HIV and AIDS stigma than their older counterparts (Logie & Gadalla, 2009). In further contrast, results of a study conducted by Wagner et al. (2010) found no association between age and HIV and AIDS stigma. This is empirically supported by findings of the studies by Wolitski et al. (2009), and Vanable, Carey, Blair, and Littlewood, (2006), where age was found not to play any role in the experiences of HIV and AIDS stigma among their participants (HIV positive women). In agreement with results of Wagner et al. (2010), and Wolitski et al. (2009), are findings of a study by Visser et al. (2009) who found no association between the two aspects, i.e., HIV and AIDS stigma and age.

With regard to relationship between age and psychological functioning, HIV and AIDS stigma is documented to adversely impact the wellbeing of older adults (UNAIDS, 2013), and has been associated with depression, anxiety, poorer quality of life, non-disclosures, and loneliness (Emlet et al., 2013; Grov, Golub, Parsons, Brennan, & Karpiak, 2010; Haile et al., 2011). Research reveals that higher rates of HIV and AIDS stigma are found to predispose older adults to increased risk for major depressive symptoms (Grov et al., 2010). However, these above challenges were found to be mediated by social support. With adequate social support and adaptive coping, old age was found to be associated with reduced psychological dysfunctions (Emlet et al., 2013).

In agreement, in a cross-sectional study conducted by Storholm et al. (2013) to establish if HIV and AIDS stigma mediates the relation between multiple-minority status (e.g., older age group, race) and mental health burden in an aging HIV-positive population, their findings indicated a clear association among multiple-minority status and perceived HIV and AIDS stigma, and mental health burden. Their findings further indicated that individuals with a greater number of minority burdens (e.g., older age, HIV and AIDS) showed increased experience of stigma with increases in poor psychological functioning among the older HIV-positive sample. Their results further demonstrated that HIV and AIDS stigma mediates the relation between minority status (age) and psychological dysfunction burden. That is, while minority status is significantly associated with psychological dysfunction burden, those of minority demographic background experience an increase in psychological dysfunction burden as a result of the increased level of HIV and AIDS stigma they experience.

The results demonstrated that HIV-positive multiple-minority individuals are experiencing more HIV and AIDS stigma than are HIV-positive non-minority individuals. The findings further show that the experience of HIV and AIDS stigma is significantly associated with overall lowered psychological functioning with increased age. This finding is consistent with results of other studies (DeGrezia & Scrandis, 2015; Storholm et al., 2013).

The deduction from this review is that the relationship between age and HIV and AIDS stigma experiences is not consistent (due to other factors such as social support that can adjust the relationship thereof). However, with regard to the psychological dysfunctions, age is found to be a perpetuating factor. Studies in South Africa that are aimed at reducing psychological dysfunctions among PLWHA that included age as a variable are non-existent. Thus, results of this study will further enhance knowledge and literature on psychological dysfunction reduction interventions among PLWHA in South Africa.

3.6 Duration of Diagnosis and HIV and AIDS Stigma

According to Cahill and Valadéz (2013), there is great variation of experience between PLWHA who were recently diagnosed and those diagnosed early in the epidemic. PLWHA diagnosed in the 1980s, before effective treatments, struggled with shame and uncertainties related to the disease due to persistent stigma. Such pattern continues even up to the present (Cahill & Valadéz, 2013).

Determination of the relationship between duration of diagnosis, HIV and AIDS stigma and psychological functioning is therefore vital. Studies have rarely included duration of diagnosis as a variable when exploring dynamics around HIV and AIDS stigma and psychological dysfunctions, resulting in the scarcity of literature on the phenomenon in question.

Nonetheless, the few studies conducted indicate that there is a positive relationship between duration of diagnosis and HIV and AIDS stigma, with the longer the duration of HIV and AIDS diagnosis, the greater the likelihood of experiencing stigma enactments (Herek et al., 2013; Igumbor et al., 2012). Additionally, results of a study by Relf and Rollins (2015), show that long duration of diagnosis was found to not make HIV and AIDS stigma experience better among the their participants. That is, participants still struggled with HIV and AIDS stigma regardless of their long duration of living with HIV disease.

Furthermore, in the study by Côté et al. (2015) on psychosocial profile and lived experience of HIV-infected long term or slow progressors, it was noted that PLWHA were still found to be vulnerable to stigma-induced psychological problems regardless of the long duration of their illness. They were found to experience symptoms of depression and anxiety due to the stigma of having to live for a long time with the condition. This finding is consistent with results of the study by Herek et al. (2013).

Based on the findings of these studies reviewed, long duration of HIV-positive diagnosis is empirically found to be associated with greater experience of HIV and AIDS stigma and psychological dysfunctions. However, none of these studies were conducted in the South African context, hence a gap exists in the knowledge.

3.7 HIV and AIDS Stigma Interventions

Due to the pervasive nature of HIV and AIDS stigma (UNAIDS, 2013), studies show that the epidemic is continuing to negatively impact the psychological functioning of those living with the virus (Su, Lau, Mak, Chen, & Choi, 2013; Wang, Li, Barnett, Zhao & Zhao, 2012), and to spread in sub-Saharan Africa, including South Africa (Massyn et al., 2013). Interventions to alleviate HIV and AIDS stigma and its subsequent psychological dysfunctions are therefore fundamental.

However, literature as reviewed by Brown et al. (2003) has revealed that there are few published studies on HIV and AIDS stigma-reduction interventions, particularly in sub-Saharan Africa, including South Africa. They systematically reviewed twenty two (22) HIV stigma-reduction intervention studies in developed and developing countries published in peer-reviewed journals before December 31, 2001. Most of these studies were conducted in the United States (13 out of 22), three were carried out in other developed countries (Canada, England, and Scotland), six took place in Nigeria, one in Uganda, and one in South Africa. Results of their review indicate that most of the interventions studies reviewed were not aimed solely at reducing HIV and AIDS stigma, but involved many other components as well such as increasing awareness and knowledge of HIV and AIDS, promoting behaviour change, etc., but they did however include the stigma component within those interventions.

From the review, Brown et al. (2003) classified the intervention strategies into four categories. The first category is information based, which encompasses fact-based information conveyed verbally or in written form such as pamphlets and verbal presentations.

The second category is skills based, where individuals are equipped with skills to cope with HIV and AIDS stigma. Thirdly, counselling, where the core is providing support by dealing with distressing concerns with regard to HIV and AIDS stigma. Lastly is contact with the stigmatised group or individual. This includes direct or indirect interactions with the stigmatised individual or group, in the form of face-to-face interaction or recorded testimonials. They found that the common approach employed was information based education. They established that most studies in their review demonstrated information coupled with skills intervention to be more effective in increasing knowledge and reducing stigma than information alone (Brown et al., 2003). The gap in Brown et al.'s (2003) review is the absence of a systematic review to determine the effectiveness of interventions in reducing HIV and AIDS stigma.

It is on that note that Sengupta et al. (2011) expanded the work of Brown et al. (2003) by conducting a systematic review to determine quality and effectiveness of stigma reduction intervention programmes that measured stigma at pre-and post-intervention. The systematic review was from nineteen (19) published studies. Unlike Brown et al. (2003), they did not restrict their review to publication date; their latest articles were March 2009. They also did not limit the HIV interventions specifically to have a stigma reduction component, as long as HIV and AIDS stigma reduction was reported post intervention regardless of the type of HIV-related intervention used.

In terms of Brown et al. (2003)'s intervention categorisation, nine of the studies they reviewed employed the information approach, two employed three of the four intervention categories, excluding counselling, and one study employed all the four intervention categories, i.e., information, skills building, counselling and contacts with the stigmatised individuals. With regard to study designs, of the nineteen studies that they reviewed, nine were randomised control trials and six were non-randomised control group designs. Of the six non-randomised control trials, three studies were conducted in African countries (South Africa, Nigeria, and Botswana).

The duration of the intervention ranged from three days to one year. Of the nineteen studies, fourteen were reported to be effective in stigma reduction at post-test. Of the fourteen, only two were found to have statistically demonstrated effective HIV and AIDS stigma reduction intervention. Furthermore, amongst the nineteen studies, only one study made a comparative assessment between the HIV-infected and HIV-uninfected (Sengupta et al., 2011). The limitation of Sengupta et al.'s (2011) review is that it included HIV and AIDS intervention studies on a general level; it was not limited specifically to HIV and AIDS stigma-reduction interventions.

It is on the basis of that limitation that Stangl, Lloyd, Brady, Holland and Baral (2013) conducted a systematic review of HIV and AIDS stigma-reduction interventions specifically. The review included studies starting from 2002 to 2013, which included forty peer-reviewed articles, six grey literature reports and two dissertations. In agreement with Brown et al. (2003), most intervention studies were found to have employed more than one HIV and AIDS stigma-reduction strategies.

In their review, the most commonly employed strategy was information, followed by skills building, contact and counselling. They further found that most interventions focused most on the individual level, followed by community, organisational, interpersonal and least on public policy. In addition to Brown et al.'s (2003) intervention strategies, Stangl et al. (2013) identified and added two more strategies, i.e., structural and biomedical approaches. Structural approaches focus on societal structures such as criminalisation related to disclosure that can influence stigmatisation. The biomedical approaches focus on de-stigmatisation of counselling and testing. The findings of Stangl et al. (2013) revealed that most studies were found to be effective in HIV and AIDS stigma reduction.

However, the limitation identified here is that the studies did not assess the health outcome associated with HIV and AIDS stigma. The current study will therefore close this existing gap, as it looks into psychological dysfunctions as HIV and AIDS stigma related health outcomes.

3.8 HIV and AIDS Stigma Interventions in South Africa

There is paucity of HIV and AIDS stigma-reduction intervention programmes targeting PLWHA in South Africa with the aim of alleviating HIV and AIDS stigma and psychological dysfunctions. Nevertheless, Tshabalala and Visser (2011) developed a CBT (Cognitive Behavioural Therapy) model to help reduce HIV-related internalised stigma among black women living with HIV and AIDS in Witbank, Mpumalanga province. They employed pre-test-post-test design.

In terms of Brown et al.'s (2003) intervention strategies, they used counselling and contact intervention strategies. Their study employed twenty participants who were randomly assigned to an experimental or control group. The experimental group underwent eight sessions of CBT-based individual psychotherapeutic intervention. The intervention content mainly focused on helping the participants deal with internalised stigma. Their post-test results indicated that participants who were subjected to the intervention programme significantly demonstrated lower levels of internalised stigma, lower levels of depression, improved coping and higher levels of self-esteem than the control group. The effectiveness of the intervention in reducing HIV and AIDS stigma and psychological dysfunction was evaluated through the study of therapy transcripts, and the intervention was found to have been effective.

According to the literature reviewed, this is the only study brought to the attention of the researcher with an intervention component that clearly included psychological dysfunctions as HIV and AIDS stigma related health outcomes. However, the intervention was gender based; it was offered to females only, so it excluded males who could equally be encountering similar challenges that females are encountering. Furthermore, the intervention was limited to only one stigma dimension, which was internalised HIV and AIDS stigma, leaving out the other two stigma dimensions (perceived and enacted HIV and AIDS stigma). Hence, the content of the intervention programme was specifically tailored to deal with internalised stigma, making the intervention not easily replicable for use across all stigma dimensions.

Therefore, to address the gaps identified in this study, the intervention of the current study is not gender specific; it includes both females and males, affording males an equal opportunity to deal with their own stigma distressing issues as well. Also, a mixed gender intervention group employed in the current study gives participants an opportunity to support each other during the group, which assisted in making HIV and AIDS stigma not to be viewed from a sexist perspective. Furthermore, to fill the gap of one-dimensional stigma intervention, the current study incorporated all stigma dimensions (enacted, perceived and internalised HIV and AIDS stigma) in the intervention programme, to try to level stigma experiences in all dimensions.

The other study was carried out in North West province, South Africa, by Chidrawi, Greeff and Temane (2014), who conducted a comprehensive community-based HIV stigma- reduction intervention among eighteen PLWHA. Their intervention's main focus was to improve general health behaviour and quality of life, which included stigma reduction, reduction in signs and symptoms of HIV, and to improve treatment compliance. Stigma reduction was only part of the comprehensive programme. Similar to the current study they also utilised the pre-test post-test design. Their post-test results indicated that aspects of their participants' health behaviour improved, reducing the intensity of their HIV signs and symptoms, and improving their quality of life, following intervention.

In their study (Chidrawi et al, 2014), HIV and AIDS stigma reduction was not the primary aim of intervention programme, but general behavioural change and general wellbeing was. Also, the health-related outcome of stigma reduction was more focussed on improvement of general wellbeing and not on a specific health condition, which makes replication of the intervention to specifically deal with HIV and AIDS stigma-induced psychological dysfunctions a methodological challenge.

Other than these two studies reviewed above (Tshabalala & Visser, 2011; Chidrawi et al, 2014), there are two pilot studies, one conducted by Petersen, Hancock, Bhana and Govender (2014) in KwaZulu Natal, South Africa to evaluate the potential effectiveness of a group-based HIV counsellor who delivered intervention for treating depression in PLWHA. The other one was conducted by Uys et al. (2009) in five African countries (Lesotho, Malawi, South Africa, Swaziland, and Tanzania) evaluating health-setting-based stigma reduction intervention using a case study approach. Results of both pilot studies demonstrated effectiveness in stigma reduction. However, because the studies were pilots, reference to their results will not be made in the present study.

The studies were reviewed to give a picture of what is being done, and what still needs to be done in South Africa with regard to HIV and AIDS stigma and psychological dysfunction reduction interventions in South Africa.

3.9 Summary of the empirical studies and Identified Gaps

The literature reviewed commonly demonstrates that HIV and AIDS stigma still prevails, and continues to impact negatively on the psychological functioning of PLWHA. HIV or AIDS is still being documented as a highly stigmatised medical condition over other medical conditions, although studies that are comparative in nature are relatively few. Age and duration of diagnosis were documented to be associated with experiences of HIV and AIDS stigma and psychological dysfunctions.

The relationship between age, duration of diagnosis, with HIV and AIDS stigma and psychological dysfunctions was established, however the reviewed studies proved the nature of the relationship to be inconsistent. Among PLWHA in the South African context, dynamics of this nature were never given empirical attention, hence the present study.

It is noteworthy that there is a dearth of studies on HIV and AIDS stigma and psychological dysfunctions reduction intervention in South Africa. Most studies are limited to the exploration of HIV and AIDS stigma and psychological dysfunctions respectively, and lacked the intervention component to deal with such issues. Therefore, this study seeks to fill in the gap by designing an intervention programme to deal with HIV and AIDS stigma and psychological dysfunctions in South Africa.

3.10 Hypotheses of the Study

1. There will be differences between PLWHA and PLWHPT on stigma experiences and psychological functioning, with PLWHA experiencing more stigma and psychological dysfunctions than PLWHPT.
2. HIV and AIDS stigma, age and duration of diagnosis will predict psychological dysfunctions.
3. PLWHA who received SCSi (the experimental group) will report less stigma and improved psychological functioning than those who did not receive SCSi (the control group).

CHAPTER FOUR

4. METHODOLOGY

This chapter details the methodology employed in carrying out the study. This was a two-in-one study that comprised two phases. Phase I entailed baseline assessment, i.e., determination of participants' stigma experiences, as well as their psychological functioning. The results of the phase I study then informed the development of phase II, which was the development of the stigma reduction intervention programme, the Stigma Coping Skills Intervention (SCSI).

4.1 Phase I Study

4.1.1 Design

The study employed the quantitative approach using the cross-sectional design for phase I of the study. The cross-sectional design study has the ability to compare diverse samples (e.g., in this study, PLWHA and PLWHPT) at a single point in time, and allows the researcher to look at several aspects at once. The variables that were studied were psychological dysfunction as a dependent variable, HIV and AIDS stigma, age and duration of diagnosis as independent variables.

4.1.2 Setting of the study

The study was carried out in Capricorn District in Limpopo Province which is situated in the northern part of South Africa. The province comprises five districts namely Capricorn, Waterberg, Vhembe, Mopani and Greater Sekhukhune. The province comprises various ethnic groups differentiated by language, culture and race, with blacks as the majority (97%), whites (2.4%), coloureds and Indians (0.6%). In terms of language, the predominant languages are Northern Sotho (52.9%), Tsonga (17%), Venda (16.7%), and Afrikaans (2.6%). The province is predominantly rural, and it has only one city which is situated in Capricorn district. Capricorn district was chosen for the study because it constitutes a wide variety of racial groups as well as socio-economic levels, as people from other districts migrate to this district for economic reasons (Statistics South Africa, 2013).

The prevalence of HIV and AIDS in Limpopo province by the end of 2012 was estimated at 9.2%. The prevalence by district variations were: Capricorn, Waterberg and Mopani districts at par with 10-12%, Vhembe and Greater Sekhukhune district at 4-5% (Massyn et al., 2013; Shisana et al, 2014). Participants were recruited from the HIV and AIDS and hypertension outpatient clinic at Polokwane/Mankweng Hospital Complex (the largest hospital in the province), Rethabile Health Centre, and Takalani Nana HIV Centre, in Polokwane.

4.1.3 Instruments

The instruments that were used in the study are discussed below.

HIV and AIDS Stigma Scale

This instrument, developed by Westbrook and Bauman (1996), was used to measure HIV and AIDS stigma. The scale comprised items that assess internalised, perceived and enacted stigma. The scale had 20 items that assessed internalised stigma, 20 items that assessed perceived stigma and 9 items that assessed enacted stigma. The participants had to respond on a four point Likert scale, with 1 indicating strongly agree, and 4 strongly disagree. With regard to enacted stigma, the participants had to respond on a 3 point Likert scale with 1 indicating no experience and 3 indicating a lot of experience. There were items that needed to be reversed. For internalised stigma the following items were reversed: Items 10, 12, 17, 18, 19, 25, 26. For perceived stigma the reversed items were: Items 30, 32, 37, 38, 39, 45. For enacted stigma items no reverse was required. High scores were indicative of high stigma experience. The scale has been adapted and used among the South African population by Idemudia and Matamela (2012), and was found to be reliable (Cronbach's $\alpha = 0.88$), with a higher value indicative of high reliability. The same scale was adapted and used for the control group.

General Health Questionnaire-28 (GHQ-28)

The GHQ-28 developed by Goldberg (1972) was adapted and used (Cronbach's $\alpha = 0.92$) to assess the participants' psychological functioning. The scale is used to establish psychological symptoms experienced by an individual in the past few weeks. The participants had to respond on a four point Likert scale with 1=Better than usual, 2=Same as usual, 3=Worse than usual, 4=Much worse than usual.

The use of scoring method '0-0-1-1' was suggested by Goldberg to assist reduce biases resulting from participants who tend to choose responses 0 and 3 or 1 and 2. The higher the score, the poorer the psychological functioning of the participant. It consists of 28 items that, through factor analysis, have been divided into four sub-scales, which are as follows: A - Somatic symptoms (items 1-7) reliability (0.84), B - Anxiety/insomnia (items 8-14) reliability (0.85), C - Social dysfunction (items 15-21) reliability (0.83), and D - Severe depression (items 22-28) reliability (0.83). The scale has been adapted and used among the South African population by Idemudia and Matamela (2011) in their study among HIV and AIDS and cancer patients, and was found to be reliable (0.90).

4.1.4 Participants and Sampling Technique

For phase I, the study consisted of 600 participants, 300 PLWHA and 300 PLWHPT, for baseline assessment. Hypertension is regarded as one of the most common chronic condition with debilitating effects (Ivarsson, Ekmeahag, & Sjöberg, 2015), hence it was used to make comparison with HIV and AIDS. PLHWA were assigned to the experimental group while PLWHPT were assigned to the control group. The demographic characteristics of participants are presented in table 1 on page 76.

Notably, there was a difference in mean ages between PLHWA and PLWHPT. Mean age for PLWHPT was higher than for PLHWA. This might be due to the fact that hypertension is more common among older people (Maredza, Bertram, Gómez-Olivé, & Tollman, 2016; Peltzer & Phaswana-Mafuya, 2013). Purposive sampling method was employed, due to the nature of the study participants. Purposive sampling is a non-probability sampling method where the researcher relies on his/her own judgement to select participants based on research rationale. The notion behind purposive sampling is to focus on participants with particular characteristics who will better be able to assist with the relevant research (Etikan, Musa, & Alkassim, 2016).

Table 1. Demographic characteristics for phase I participants

	PLWHA (N=300)	PLWHPT (N=300)
Age range	20-54 yrs	36-77 yrs
Mean Age	31 (SD 8.2)	55(SD 8.10)
Gender		
Male	125(41.5%)	141(47.0%)
Female	172(57.1%)	159(53.0 %)
Missing value	3(1.4%)	-
Marital Status		
Married	89(29.6%)	158(52.7%)
Never married	169(56.1%)	99(33.0%)
Divorced	6(2.0%)	14(4.7%)
Widowed	18(6.0%)	23(7.7%)
Missing value	18(6.3%)	6(20%)
Educational Level		
Less than grade 12	35(11.6%)	131(43.7%)
Grade 12	76(25.2%)	102(34.0%)
Tertiary education	164(54.5%)	61(20.3%)
Missing value,	25(9.5%)	6(2%)
Duration of Diagnosis (DD)		
Less than 1 year	143(47.5)	33(9.3%)
2-4 years	139(46.5)	154(51.3%)
More than 5 years	18(6.0)	113(37.7%)
Grade 12	76(25.2%)	102(34.0%)

4.1.5 Procedure

The study was carried out after approval and permission was granted by the North West University, and the provincial Department of Health Ethics committees. The provincial approval letter was used to gain access to the institutions where data was collected. The research was introduced to the managing officers of the sites where data was collected.

This entailed explaining the purpose of the research and its significance, and nature of participants that would be targeted including the eligibility criteria. Eligibility criteria of the study were: being diagnosed with HIV, being diagnosed with hypertension (on self-report), and be at least 18 years of age or older to be able to give or considered competent to give informed consent. Those who appeared too ill, the mentally unstable or mentally disabled or who had any other condition that would impair their ability to consent were excluded. Before baseline data collection commenced, the purpose and significance of the study was explained to the participants. Consent was obtained from individuals who volunteered to partake in the study. The questionnaires were then administered for phase I baseline assessment.

4.1.6 Ethical Considerations

The study was approved by the North West University ethics committee as well as the ethics committee of Limpopo provincial Department of Health. Participation in the study was voluntary. For this study, no exclusion was made based on participants' socio-economic status, gender or ethnicity. Formal informed consent was sought from the participants willing to take part in the study. Confidentiality was assured for participants to feel at ease. The right not to participate, as well as to withdraw from the study at any point was outlined.

4.1.7 Data Analysis

Descriptive statistics were calculated for the demographic characteristics. To determine group differences (PLWHA and PLWHPT) in terms of stigma experiences the independent t-test was employed. To establish the correlations between variables under investigation, Pearson's correlation coefficient was used.

Structural Equation Modelling (SEM) was also employed. With SEM the variables under investigation were determined by hypothesising a model predicting the relationship of independent variables (HIV and AIDS stigma, age and duration of diagnosis) with the dependent variable (psychological functioning). The hypothesised paths that were tested were: HIV and AIDS stigma (enacted) has a direct positive relationship with psychological dysfunctions (i.e., GHQ and its entire four dimensions i.e. somatic complaints, anxiety, social functioning and severe depression); age has a direct positive relationship with psychological dysfunctions, duration of diagnosis has a direct positive relationship with psychological dysfunctions. The hypothesised model constituted three exogenous variables (independent) (HIV and AIDS stigma, age, duration of diagnosis), as well as five endogenous variables (dependent) which are psychological dysfunctions (overall GHQ and its four dimensions i.e. somatic complaints, anxiety, social functioning and severe depression).

4.2 Phase II Study

4.2.1 Design

For phase II, the pre-test-post-test control group design was used, as depicted in Figure 4 below. The pre-test-post-test design is a commonly employed design in behavioural research. It is mainly used to compare groups and/or assess change resulting from intervention programmes. The design involves randomly assigning participants with similar experiences to either the experimental or control group, and administer the pre-test to both groups. The experimental group is then exposed to an intervention programme, while the control group does not get exposed. A post-test is subsequently administered to both groups, to assess the change between the two groups following the intervention programme (Dimitrov & Rumrill, 2003).

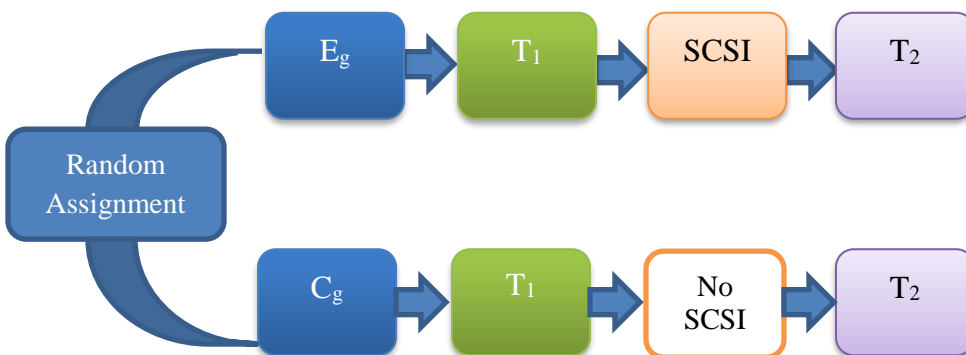


Figure 4: Pre-test-post-test control group design

Eg = Experimental group, Cg = Control group, T₁ = Pre-test, SCSI = Stigma Coping Skills Intervention, T₂ = Post-test

4.2.2 Instruments

The instruments i.e., the HIV and AIDS stigma scale and the GHQ 28 that were used in phase I study were used again in phase II for post-test to establish the efficacy of the SCSi programme in alleviating stigma and improve psychological functioning. The instrument's psychometric properties have already been outlined in phase I study.

4.2.3 Participants and Sampling Technique

For phase II, the study consisted of 24 participants selected from the baseline experimental group in phase I, i.e., PLWHA. Baseline results indicated PLWHA of younger age and less duration of diagnosis reported more stigma experiences and psychological dysfunctions, so as a result they were the ones targeted for the intervention. Twelve participants (12) were assigned to the experimental and 12 to the control group. The demographic information of participants in phase II is presented in Table 2 on page 81. Simple random sampling was done to select participants from the baseline experimental data for phase II. Simple random sampling is a sampling technique where a group of participants are selected from a larger group, where each individual has an equal chance of being included in the sample (Teddlie & Yu, 2007). Each questionnaire was allocated a unique number, and then the questionnaires were randomly selected until the required number was reached. Participants whose questionnaires were selected were contacted and invited for the intervention.

Table 2. Demographic characteristics for phase II participants

	Experimental (N=12)	Control (N=12)
Age range	20-35 yrs	20-35 yrs
Mean Age	28 (SD 3.10)	31 (SD 8.2)
Gender		
Male	5 (41.7%)	7 (58.3%)
Female	7 (58.3%)	5 (41.7%)
Marital Status		
Married	2 (16.7%)	4 (33.3%)
Never married	10 (83.3%)	7 (58.3%)
Divorced	0 (0.0%)	0 (0.0%)
Widowed	0 (0.0%)	1 (8.3%)
Educational Level		
Less than grade 12	3 (25.0%)	2 (16.7%)
Grade 12	3 (25.0%)	2 (16.7%)
Tertiary education	6 (50.0%)	4 (33.3%)
Duration of Diagnosis(DD)		
Less than 1 year	9 (75%)	6 (50.0%)
2-4 years	3 (25%)	5 (41.7%)
More than 5 years	0 (0%)	1 (8.3%)

4.2.4 Procedure

Results of the baseline assessment informed the development of the intervention programme in accordance with variables under investigation. The participants who reported experiences of stigma and psychological dysfunction at baseline were the ones targeted for the intervention. A Theory-based therapeutic approach was used by a qualified practitioner (clinical psychologist) to provide and facilitate the intervention. Objectivity was ensured at all times to guard against bias.

The participants were seen once a week for eight weeks, with an intervention programme for each week clearly outlined. After the intervention programme was completed, post-test was conducted to assess the effect of the intervention programme on HIV and AIDS stigma and psychological dysfunction. The control group were exposed to the intervention programme the experimental group had undergone for ethical reasons.

4.2.4.1 Assessment

The assessment was conducted at pre-test and post an eight week intervention programme. The same instruments discussed earlier, i.e., HIV and AIDS stigma scale and the GHQ 28 used at pre-test were also used at post-test.

4.2.4.2 Experimental Conditions

Phase II study consisted of two groups: the experimental (participants exposed to the SCSi) and the control group (participants not exposed to the SCSi). The experimental group met at least once a week for eight weeks. The duration of each session was 60-90 minutes. The group was facilitated by the researcher herself, who is a qualified clinical psychologist registered with the Health Professions Council of South Africa (HPCSA), with four years of experience in clinical practice. Objectivity was ensured at all times to guard against bias.

4.2.4.3 Group Process (The Stigma Coping Skills Intervention-SCSI)

The group process of the SCSI programme was conducted in accordance with Yalom's group therapy approach as discussed in detail in chapter two. As a sense of belonging and group membership is essential for self-concept formation, as postulated by social identity theory (Ellemers & Haslam, 2012), group therapy was considered relevant for intervention with this population. Group therapy will enhance a sense of belonging, group membership and homogeneity when participants realise that there are other people in a similar situation.

The SCSI was both a time-limited and focused therapy group. The two are described as follows: focused therapy group is a group that is based on a specific topic or problem area that all group members have, that is, it focuses on homogeneous problem. Hence, the present study entailed only PLWHA with experiences of stigma and psychological dysfunctions. Focused therapy groups are skill development groups as well, assisting members learn coping skills and/or changing maladaptive behaviour. The focused therapy group can either be open-ended or time-limited.

Those with a skills development component are mostly time-limited; the groups usually run between eight and ten sessions. Time-limited groups have a beginning, middle and end, and do not add new members after the first few sessions had started (Yalom, 1995). The intervention was anchored on the CBT (Cognitive Behavioural Therapy) approach, offered by a qualified clinical psychologist as outlined earlier on with the purpose of enhancing participants' psychological functioning.

Based on Brown (2003)'s intervention strategies, the SCSI programme employed a combination of information, skills building and psychotherapeutic strategy. Below is an outline of the SCSI programme:

Session 1: Group Formation

During group formation, pre-group preparation was done for the smooth running of the group which involved paying attention to early group discomfort, encouraging member-to-member interaction, and modelling appropriate behaviour for solid foundation laying. This is the session during which clear goals were set: setting group norms, setting basic group ground rules such as respect for each other, encouraging participation and taking care of participants' own needs. Confidentiality was especially emphasised during this session. This was done to promote trust, openness and loyalty to the group. Rapport building with participants was established. Ice-breakers were used to make participants feel at ease. The participants were given the chance to know each other by introducing themselves to members of the group. Introduction of the purpose of group was done by the facilitator, who is the researcher.

The selection criteria, the how and why participants were selected to participate in the group, were outlined. An outline of ethical aspects to be observed was made with special emphasis on confidentiality. An outline of the course of the intervention programme was made as well in this session to make participants aware of the nature of the programme and aspects to expect in subsequent sessions. This entailed the duration of the programme as well as aspects that would be covered.

Session 2: Identification of Stressors and Coping Mechanisms

In this session, participants were afforded an opportunity to freely relate and vent out their personal stressors and experiences in relation to HIV and AIDS stigma in a safe and supportive environment. As was indicated earlier on that the intervention was informed by the results of the baseline assessment, baseline results showed that PLWHA experienced HIV and AIDS stigma from all dimensions (i.e., internalised, perceived and enacted HIV and AIDS stigma), but enacted HIV and AIDS stigma was experienced significantly more often relative to other stigma dimensions. As a result, the intervention comprised all the stigma dimensions, although emphasis was put more on the enacted. Participants' feelings were acknowledged and normalised with unconditional positive regard. Those who became emotionally distressed as they related their experiences were contained. The participants were also given a chance to relate and share coping strategies they use to deal with their stigma experiences. Maladaptive coping skills were reported by group members, such as avoidance or disengagement. For example, a 27 years old male reported: *“With me, what has kept me going is I just avoided thinking about the treatment I am receiving from my family”*.

Session 3: HIV and AIDS Knowledge (Information Empowerment)

Review of the participants' basic HIV and AIDS knowledge was done to establish their level of knowledge, so as to equip them with adequate information. The following were some of the questions that were asked to determine their basic knowledge base.

- **HIV and AIDS Basic Information:**

- What is HIV?
- What is AIDS?
- Are HIV and AIDS the same thing?

- **Transmission Mode**

Will a person get HIV by doing the following?

- Hugging an HIV positive person.
- Shaking hands with an HIV positive person.
- Sharing a glass of water with an HIV positive person.
- Sharing a toilet with an HIV positive person.
- Eating from same plate with an HIV positive person.
- Sharing a bed with an HIV positive person.
- Semen and vaginal fluids during sexual intercourse.
- Contact with infected blood.
- Blood transfusion.

The facilitator conducted the discussion of the questions in an interactive manner during group session, and thereafter psycho-education on HIV and AIDS basic information including transmission modes was provided by the facilitator.

Group members seemed to have fairly adequate basic HIV and AIDS knowledge. For example, a 25 year-old female reported, *“We know most of these things; this information was provided to us when we were initiated on ARVs, but the way people treat HIV positive people, one ends up even confused not knowing what the truth is about this disease. It is like the moment you open your mouth, you will just be spreading the HIV virus all over”*.

Session 4: Communication Skills (Skills Empowerment)

The participants were empowered with healthy and effective communication skills which included role plays as well as take-home practice tasks. The take-home tasks required them to apply the skills learnt in stigmatising situations they encounter in their respective settings, to alleviate the distress that usually arises from maladaptive communication patterns. Most of the participants seemed to have had challenges with communicating effectively. For instance a 28 year-old male reported: *“I find this communication training helpful. Before I used to argue a lot with my elder brother every time I felt he was offending me regarding my status. We would end up screaming at each other. I remember this other day I threw a jug of water on his face out of frustration”*.

Session 5: Assertive Skills - (Skills Empowerment)

The participants were equipped with assertive skills so as to enable them to assert themselves when confronted with distress in stigmatising situations. This included equipping them with skills to stand their ground without being arrogant, learn under which circumstances they need to be assertive, learn differences between assertiveness and arrogance.

Assertive training also included role plays among the group members, as well as take-home tasks to exercise the skills learnt. Most group members seemed to have lacked assertiveness, and did not know how to assert themselves. For instance, a 25-year old female reported, *“before my ex-boyfriend broke up with me, I used to do things that he would decide on my behalf with regard to my illness; things I was not happy with, but for some reason, I couldn’t tell him that I was not happy, and I would always feel bitter about it”*.

Session 6: Cognitive Restructuring- CBT orientated (Psychotherapeutic)

Psychological interventions aimed at dealing with depression and anxiety among PLWHA that have a cognitive behavioural dimension have been found to be effective (Sherr et al., 2011), hence the CBT was the psychotherapeutic approach of choice for the intervention programme of the present study. During the intervention, HIV and AIDS stigma was tackled according to its dimensions, for example:

- Internalised HIV and AIDS stigma: Goffman (1963) has postulated that individuals who are stigmatised tend to internalise the tarnished mark or label (e.g. sexually immoral) imposed upon them by the stigmatisers, resulting in internalised stigma. This often manifests in the form of self-defeating thoughts and self-blame predisposing them to psychological dysfunction. As a result the self-defeating, and irrational thoughts that lead to internalisation of stigma were challenged and disputed. For example, a 33 year-old female reported: *“It is very difficult for me to move forward with life with this diagnosis; every time I felt I brought this to myself.”*

- Perceived HIV and AIDS stigma: Due to the knowledge that PLWHA are perceived negatively and as a result are avoided, this knowledge therefore precipitated perceived stigma among PLWHA. Mind-reading cognitive distortions that lead to stigma anticipation and perception were also challenged and disputed. A 30 year old female reported for example *“Every time I walked in our social club, we are about twenty in number, and when they started laughing, I’d always think they were laughing at me, even though I never disclosed my status to them. Or, if the person next to me decided to change seats for some reason, to me it was like, she does not want to sit next to a person with AIDS. I eventually quit the club.”*
- Enacted HIV and AIDS stigma: Enacted stigma here is viewed from social identity theory, disease avoidance model, and magical law of contagion discussed in detail in chapter two. Reframing, providing alternative interpretations of stigmatising behaviours was done to reduce and avoid distress.
- An example of an alternative interpretation was to perceive stigma enactments as indication of lack of knowledge and a call for more HIV and AIDS education. Henceforth the group mutually came up with a motto to assist them to cognitively cope with stigmatising enactments. The motto was: *I don’t have a problem, with my status, if you have, it is your problem.* A 27 year-old male shared: *“My aunt was not aware that I was in the house, I overheard her telling my cousin that she should not wash the plate that I was eating in with the rest of the dishes. I felt really bad; I felt like I was trash.”*

Session 7: Stress management - (Information Empowerment)

As it is well documented in research that stigmatising attitudes elicit stress to the sufferer (Bhatia & Munjal, 2014), psycho-education on healthy stress management strategies was provided in this session. Most group members seemed to have maladaptive stress management strategies. For example, a 28 year-old male shared with the group: *“when I get stressed-up, I smoke (cigarette). I must confess these days I’m becoming a heavy smoker. It’s frustrating because every time I finish smoking, then I start feeling guilty because I know well that smoking is not good for my health.”* The following were quick-to-use stress-busting strategies that participants were equipped with:

- Speak up; don’t bottle up your feelings.
- Don’t allow petty things to upset you (mind readings e.g. when people are laughing while you are approaching, don’t assume they are laughing at you).
- Hobbies and distractions (do something that interests you).
- A daily dose of humour and laughter is excellent in combatting stress.
- Exercise (contextualised, considering participants socio-economic background)
- Have enough rest/sleep

Session 8: Closure/Termination

This session involved recapping of aspects and skills learnt in preceding sessions, and wrapping up the programme. The participants were given a chance to bid each other farewell. Words of encouragement and well wishes in the fight against stigma were given by the group.

The participants reported to have benefited a lot from the programme. For instance one participant reported: *“When I joined the group, I felt like I was carrying bags and bags of cement on my shoulders, now all that is gone; I feel very light and ready to face the world, thanks to the programme.”* A post-test was then administered, using the same instrument that was used during the pre-test. The control group was also exposed to the intervention after they had completed the post-test, for ethical reasons.

4.2.5 Phase II Data Analysis

For phase II study, the paired sample t-test was used to compare group (experimental and control) differences, and the ANCOVA was used to determine the effect of the SCSI programme on HIV and AIDS stigma and psychological functioning. The ANCOVA is a form of analysis of variance performed with the aim of taking into account the effects of the independent variable on the dependent variable. It affords a way of statistically controlling the effect of variables one does not want to examine in a study, which are called covariates. ANCOVA is used in experimental studies when researcher wants to eliminate the effects of some antecedent variable (Leech, Barrett, & Morgan, 2005). For instance, pre-test scores are used as covariates in pre-test-post-test experimental designs. In such instances, the covariate (pre-test of HIV and AIDS stigma and psychological dysfunction) is a measurement, taken on each experimental unit before the intervention (SCSI) is offered, that predicts to some degree the final response (post-test) on the unit.

CHAPTER FIVE

5. RESULTS

In this chapter the findings of the study are presented. Phase I (baseline assessment) results will be presented first followed by phase II (intervention) results. Independent t-test results are presented depicting differences of variables under investigation between the experimental group (PLWHA) and the control group (PLWHPT). Correlations between the variables under investigation are also presented, thereafter the SEM results with their regression weights. Lastly, phase II results of ANCOVA showing effects of the intervention on HIV and AIDS stigma and psychological functioning are presented.

5.1 Phase I Results

Hypothesis 1:

There will be differences between PLWHA and PLWHPT on stigma experiences and psychological functioning, with PLWHA experiencing more stigma and psychological dysfunction than PLWHPT. The hypothesis was tested using independent t-test. The stigma dimensions considered are i) internalised, ii) perceived and iii) enacted.

The test results showed that PLWHA significantly experienced higher enacted stigma ($t=-11.79$, $P< .001$) than PLWHPT ($\bar{x}=11.28$, $SD=1.81$ vs $\bar{x}=9.00$, $SD=.00$). PLWHPT experienced higher internalised stigma than PLWHA ($\bar{x}=64.60$, $SD=2.81$ vs $\bar{x}=44.53$, $SD=8.82$). This difference was statistically significant ($t=37.56$, $P< .001$). Also, PLWHPT had significantly higher ($t=41.71$, $P< .001$) experiences of perceived stigma than the PLWHA ($\bar{x}=60.57$, $SD=2.22$ vs $\bar{x}=43.29$, $SD=6.82$).

PLWHA's overall psychological functioning (GHQ) was found to be poorer (\bar{x} =67.24, SD=11.34 vs \bar{x} =64.65, SD=6.12) than among PLWHPT, and was significantly different (t = -3.43, P < .001). Also, all the GHQ dimensions (anxiety, social functioning and severe depression) were significantly higher across PLWHA than PLWHPT, except for somatic complaints which were significantly higher among PLWHPT than PLWHA (see table 3 below). Hypothesis one is therefore partially accepted.

Table 3. Independent sample t-tests-on stigma dimensions and psychological function between study groups at baseline

Variable	PLWHA (N=300)		PLWHPT (N=300)		t	P
	M	SD	M	SD		
INS	44.53	8.82	64.60	2.81	37.56	.00**
PSC	43.29	6.82	60.57	2.22	41.71	.00**
ENS	11.28	1.81	9.00	.00	-11.79	.00**
Overall GHQ	67.24	11.34	64.65	6.12	-3.43	.00**
SC	16.45	3.35	20.24	1.81	17.26	.00**
ANX	17.55	3.45	14.58	1.77	-13.28	.00**
SF	16.89	3.39	15.32	2.66	-6.27	.00**
SD	16.50	3.30	14.51	1.75	-9.12	.00**

INS = Internalised stigma, PSC = Perceived stigma, ENS = Enacted stigma, GHQ = General Health Questionnaire, SC = Somatic Complaints, ANX = Anxiety, SF= Social Functioning, SD= Severe Depression
* P < .05, ** P < .001

The Pearson's correlation coefficients were calculated to provide the base for the test of significance in order to inform the SEM on which variables to include in the model. Only variables that were found to significantly correlate were included in the SEM model and the intervention programme eventually. The variables that were not significantly correlated were as a result not included in the path analysis, hence internalised and perceived HIV and AIDS stigma were excluded in the model.

The Pearson's correlation coefficients revealed a significant positive correlation between enacted stigma and overall GHQ ($r = .22, p < 0.001$), and all its dimensions (somatic complaints ($r = .23, p < 0.001$), anxiety ($r = .16, p < 0.001$), social functioning ($r = .14, p < 0.05$), and severe depression ($r = .22, p < 0.001$) and any other variable under investigation. Enacted stigma was found to be negatively correlated to age significantly ($r = -.13, p < 0.001$) as well as duration of diagnosis ($r = -.05, p < 0.001$). Significant positive correlation was found between age and perceived stigma ($r = .08, p < 0.001$) as well as duration of diagnosis ($r = .18, p < 0.001$). Duration of diagnosis was found to have a significant positive correlation with internalised stigma ($r = .24, p < 0.001$).

In terms of interrelations between the stigma dimensions, there was a significant positive correlation found between enacted and perceived stigma ($r = .05, p < 0.001$). Internalised stigma was negatively correlated with enacted stigma significantly ($r = -.07, p < 0.001$). With regard to psychological dysfunction in relation to age, a significant negative correlation was found between overall GHQ and age ($r = -.23, p < 0.001$), and all its dimensions, anxiety ($r = -.21, p < 0.001$), social functioning ($r = -.19, p < 0.001$), and severe depression ($r = -.29, p < 0.001$) except for somatic complaints (see table 4 below).

Table 4. Correlation coefficients of association between psychological dysfunction, HIV stigma and psychosocial factors among PLWHA

Variables	1	2	3	4	5	6	7	8	9	10
1. GHQ	1									
2. SC	.79*	1								
3. ANX	.87*	.61**	1							
4. SF	.85**	.55**	.69**	1						
5. SD	.84**	.53**	.64**	.64**	1					
6. INS	-.08	-.05	-.06	-.16**	-.07	1				
7. PSC	-.03	-.02	-.03	-.02	-.06	.69	1			
8. ENS	.22**	.23**	.16**	.14*	.22**	-.07**	.05**	1		
9. Age	-.23**	-.10	-.21**	-.19**	-.29**	.13	.08**	-.13**	1	
10. DD	-.19**	-.14*	-.18**	-.17**	-.21**	.24*	.18**	-.05**	.52*	1
Mean	67.24	16.45	17.55	16.88	16.50	44.53	43.29	11.28	31.02	1.52
SD	11.34	3.35	3.45	3.39	3.30	8.82	6.82	3.35	8.19	.50
Skewness	.27	.59	.04	.59	.55	.62	.28	2.28	.06	-.10
Kurtosis	-.57	.51	-1.03	-.62	-.22	1.28	-.08	5.37	1.23	-2.00

GHQ = General Health Questionnaire, SC = Somatic Complaints, ANX = Anxiety, SF= Social Functioning, SD= Severe Depression, INS = Internalised stigma, PSC = Perceived stigma, ENS = Enacted stigma, DD = Duration of Diagnosis. Correlation is significant at the 0.01 level (2 tailed); *P < .05, **P< .001

Hypothesis 2:

HIV and AIDS stigma, age, and duration of diagnosis will predict psychological dysfunctions. The hypothesis was tested using SEM as shown in Table 6 (on page 101) and Figure 5 (on page 102).

To assess model fit a number of indices were calculated; however, as it is reported in the literature that it is not important to report every index in the programme output (Hooper, Coughlan, & Mullen, 2008), only the most regularly reported fit indices as recommended by McDonald and Ho (2002) will be outlined. The degree of freedom (*df*), Chi square (χ^2), relative/normed Chi-Square (χ^2/df), Root Mean Square Error of Approximation (RMSEA), Goodness-Fit Index(GFI), Adjusted Goodness-of-Fit (AGFI), Normed-Fit Index (NFI), Root Mean Square Residual (RMR) will be reported (see table 5 on page 99).

The Chi-Square assesses the overall model fit and establishes the magnitude of discrepancy between the sample and the fitted covariance matrices (Hu & Bentler, 1999). For a good fit model, the Chi-Square result should be insignificant at 0.05 (Barrett, 2007). For the current study an insignificant Chi-Square value was found, $\chi^2 = 22.69$, $df=28$, $p=.749$, demonstrating good model fit. Regardless of Chi-Square being a popular fit statistic test, it does have limitations. The first limitation is that it accepts multivariate normality; as a result severe nonconformities from normality may lead to model rejection even though the model is accurately indicated (McIntosh, 2006). Its other limitation is that since it is a statistical significance test, it is sensitive to sample size, that is, it mostly rejects the model when large sample sizes are used (Jöreskog & Long, 1993).

In instances where the sample size is small the Chi-Square lacks statistical power to distinguish between good and poor fitting models (Kenny & McCoach, 2003).

The sample size of the current study was somewhat small, therefore to counteract the Chi-Square sample size impact limitation, the relative/normed Chi-Square (χ^2/df) was calculated (Wheaton, Muthen, Alwin, & Summers, 1977) with a value of .810 demonstrating poor fit. The acceptable cut-off ratio is recommended at a range from as high as 5.0 (Wheaton et al., 1977) to as low as 2.0 (Tabachnick & Fidell, 2007); however, there is no consensus with regard to an acceptable ratio for this statistic (Hooper et al., 2008).

The RMSEA is one of the most enlightening fit assessment indices, as it is sensitive to the number of estimated parameters in the model. It indicates how good the model with unidentified but optimally selected parameter estimates would fit sample covariance matrix (Byrne, 1998). The RMSEA value less than .05 indicates good fit, 0.0 indicates perfect fit, from .08 to .10 indicates mediocre fit, greater than .10 indicates poor fit (Hu & Bentler, 1999). The RMSEA value of the model of the current study is .000, indicating a perfect fit.

The GFI computes the ratio of variation that is accounted for by the estimated sample covariance (Tabachnick & Fidell, 2007). GFI equal to or greater than .90 indicates a good fit, closer or equal to 1 indicates a perfect fit (Miles & Shevlin, 1998).

The AGFI is the adjusted GFI, it adjusts the GFI for degrees of freedom, resulting in lower values for models with more parameters. Like the GFI, AGFI values equal to or greater than .90 indicate good fit, closer or equal to 1 indicate a perfect fit (Tabachnick & Fidell, 2007). With the GFI=.980 and AGFI=.974, the model of the current study demonstrates perfect fit.

This NFI statistic weighs the model by comparing the χ^2 value of the model to the χ^2 of the null model. Its cut-off scores range between 0 and 1 with scores greater than 0.90 indicating a good fit, and 1 indicating perfect fit (Bentler & Bonnet, 1980). However, a major limitation to this index is its sensitivity to sample size too, underestimating fit for samples less than 200 (Bentler, 1990). As a result it is not suggested to be exclusively depended on (Kline, 2005). The NFI of the model of the study is = .000, indicating a poor fit. This can be attributed to its sample size limitation, as the sample size for baseline experimental group (PLWHA) was 300; as a result other fit indices will be considered in model fit assessments as recommended by Kline (2005).

The RMR is the square root of the variance between the residuals of the sample covariance matrix and the hypothesised covariance model. With the RMR, the smaller the value, the better the model fit; a value of zero indicates a perfect fit. The nearer the value to 0, the better the model fit. A value smaller than 0.05 indicates good fit (Kline, 2005); the model in the study demonstrated good fit with RMR = .405.

Table 5. Summary of fit indices of the model for the full structural equation

Model	df	χ^2	χ^2/df	RMSEA	GFI	AGFI	NFI	RMR
1.	28	22.69	.810	.000	.980	.974	.000	.405

Therefore the hypothesised model of the study generally fits the data for the sample, as a result, the path analysis was generated (see Figure 5 on page 102 for the path analysis).

Path analysis revealed the following directional relations between variables under investigation (see table 6 on page 100). Enacted HIV and AIDS stigma was found to have a significant direct relationship with GHQ ($\beta = .198, p < .01$) and all its dimensions, somatic complaints ($\beta = .223, p < .01$), anxiety ($\beta = .142, p < .001$), social functioning ($\beta = .117, p < .05$), severe depression ($\beta = .180, p < .001$). With regard to age and duration of diagnosis, enacted HIV and AIDS stigma was found to have a significant indirect relationship with age ($\beta = -.126, p < .05$), an insignificant indirect relationship with duration of diagnosis ($\beta = -.054, p = ns$). Age was found to have a significant indirect relationship with global GHQ ($\beta = -.140, p < .05$) and all its dimensions, anxiety ($\beta = -.145, p < .05$), social functioning ($\beta = -.123, p < .05$) and severe depression ($\beta = -.209, p < .001$), except for somatic complaints ($\beta = -.077, p = ns$). GHQ and all its dimensions were found to have a non-significant indirect relationship with duration of diagnosis. Hypothesis two was therefore partially accepted.

Table 6. Standardized regression coefficients of the variables

Variables	Direct Effects	Estimate	S.E	C.R	P
GHQ<---Enacted	.198	.665	.200	3.328	***
SC<--- Enacted	.223	.223	.056	3.945	***
ANX<--- Enacted	.142	.145	.058	2.506	**
SF<--- Enacted	.117	.118	.057	2.061	*
SD<--- Enacted	.180	.176	.058	3.055	**
Age <--- Enacted	-.126	-.308	.140	-2.194	*
DD <--- Enacted	-.054	-.008	.009	-.936	Ns
GHQ<--- Age	-.140	-.192	.093	-2.071	*
SC <--- Age	-.077	-.031	.023	-1.359	Ns
ANX <--- Age	-.145	-.061	.028	-2.197	*
SF <--- Age	-.123	-.051	.027	-1.853	*
SD <--- Age	-.209	-.083	.027	-3.115	**
GHQ <--- DD	-.116	-2.610	1.519	-1.718	ns
ANX <--- DD	-.101	-.690	.449	-1.537	ns
SF<---DD	-.099	-.664	.444	-1.495	ns
SD<---DD	-.096	-.623	.438	-1.424	ns

DD = Duration of Diagnosis, GHQ = General Health Questionnaire, SC = Somatic Complaints, ANX = Anxiety, SF = Social Functioning, SD = Severe Depression

*P < .05, **P< .001, ***P<.01

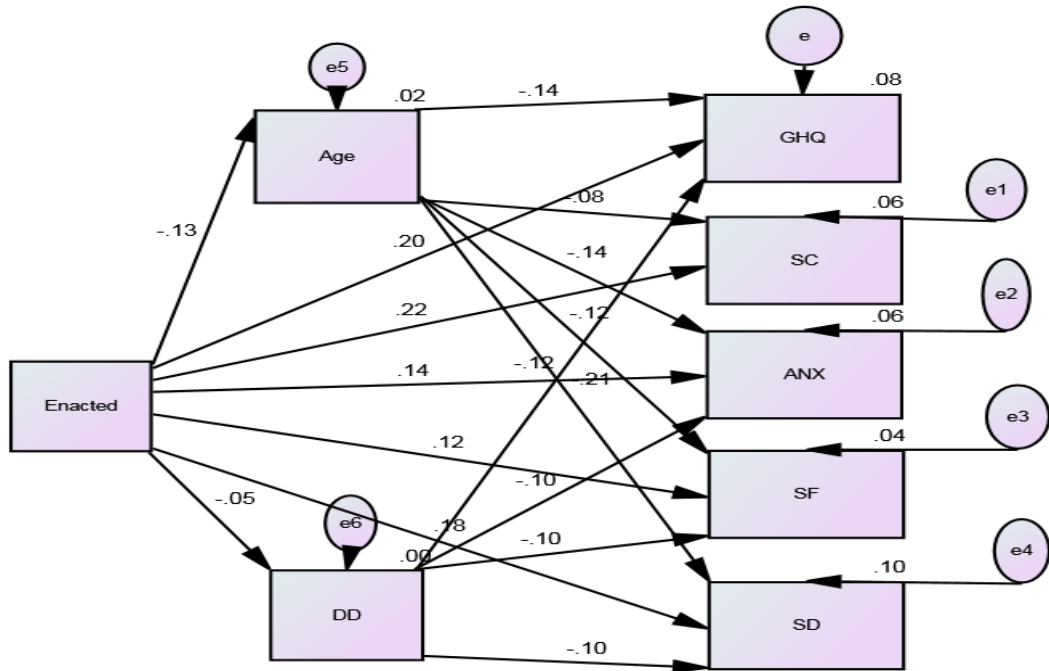


Figure 5. Path diagram of age, duration of diagnosis, enacted HIV stigma and psychological function.

Enacted = Enacted stigma, DD=Duration of Diagnosis, GHQ = General Health Questionnaire, SC = Somatic Complaints, ANX = Anxiety, SF= Social Functioning, SD= Severe Depression.

5.2 Phase II Results

Hypothesis 3:

PLWHA who received the SCSi (the experimental group) will report less stigma and improved psychological functioning than those who did not receive SCSi (the control group).

The paired sample t-test and ANCOVA were used to test the hypothesis. The results indicated that the intervention was significant on internalised and enacted stigma when pre-and post- intervention scores were considered. However, the intervention was not significant on perceived stigma. The interaction between the groups (intervention and control) and variables at baseline (e.g., GHQ) did not demonstrate statistical significant difference. The intervention was significant for the overall GHQ and all its dimensions. The pre- and post- intervention scores were significantly different ($p < 0.001$) for all the dependent variables, (enacted HIV and AIDS stigma, GHQ and all its four dimensions - somatic complaints, anxiety, social functioning and severe depression), as shown in table 7 on the next page.

Table 7. Effects of Intervention on the experimental group by stigma dimensions and by psychological functioning

Variables	Pre-test		Post-test			
	M	SD	M	SD	T	p
INS	52.54	2.23	45.83	11.61	4.39	.00**
PSC	48.08	8.33	45.25	3.31	-.56	.56
ENS	15.58	5.21	9.00	.00	-4.37	.01**
Overall GHQ	77.58	10.48	28.42	.99	-16.15	.00**
SC	18.83	3.74	7.08	.29	-4.61	.00**
ANX	19.58	2.12	7.00	.00	-5.31	.00**
SF	19.58	3.85	7.33	.89	-3.55	.02*
SD	19.58	3.03	7.00	.00	-3.76	.01**

INS = Internalised stigma, PSC = Perceived stigma, ENS = Enacted stigma
 GHQ = General Health Questionnaire, SC = Somatic Complaints, ANX = Anxiety, SF= Social Functioning,
 SD= Severe Depression. *P < .05, **P< .001

The ANCOVA model was run to determine the effect of the SCSII on enacted HIV and AIDS stigma (see table 8 on page 105). The results revealed the group was statistically significant with regard to enacted HIV and AIDS stigma post-intervention. That is, the type of group (intervention or control) participants belonged to had an effect on enacted stigma post- intervention (p<0.001). But enacted HIV and AIDS stigma at baseline was insignificant with enacted HIV and AIDS stigma post- intervention.

There was no difference in the effect of groups on post-intervention enacted HIV stigma when interaction between the enacted at baseline and the groups was explored.

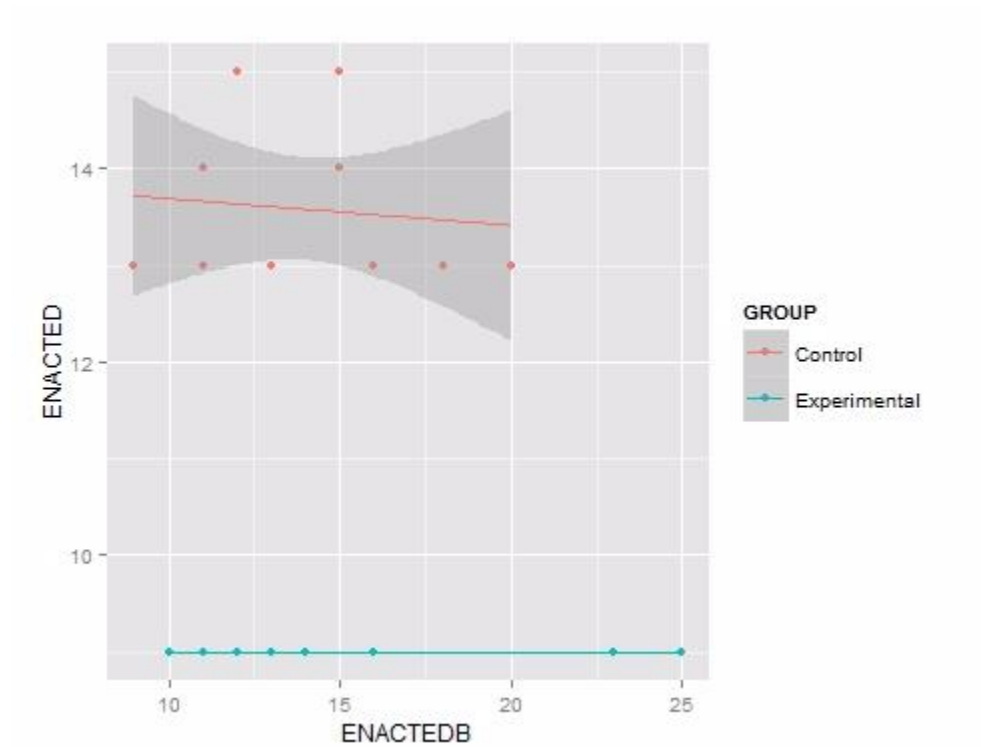
Table 8. Covariates of post-intervention enacted stigma

Source	SS	DF	MS	F	P	Np
Corrected Model	126.12	2	63.032	191.988	.000	.948
Intercept	224.348	1	224.348	683.337	.000	.970
ENS B	.022	1	.022	.067	.798	.003
Group	120.930	1	120.930	368.340	.000	.946
Error	6.895	21	.328			
Total	3193.000	24				

Group = Intervention + Control, ENS B = Enacted stigma at baseline, R Square = .949
(Adjusted R Squared = .941)

Enacted HIV and AIDS stigma post-intervention among the experimental group was very significantly low compared with the control group (see graph 1 on page 106). This shows that the SCSi programme was distinctively effective.

Graph 1. Distribution of enacted HIV and AIDS stigma at pre-and post-intervention



ENACTEDB = Enacted HIV and AIDS stigma at baseline (pre-intervention), ENACTED = Enacted HIV and AIDS stigma post-intervention

Results demonstrated that group was significant statistically with regard to GHQ at post-intervention. That is, the type of group (intervention or control) participants belonged to had an effect on GHQ at post intervention ($p < 0.001$), although, GHQ at baseline was insignificant with GHQ post-intervention. There was no difference in the effect of groups on post-intervention GHQ when interaction between the GHQ and the groups was considered (refer to table 9 on the next page).

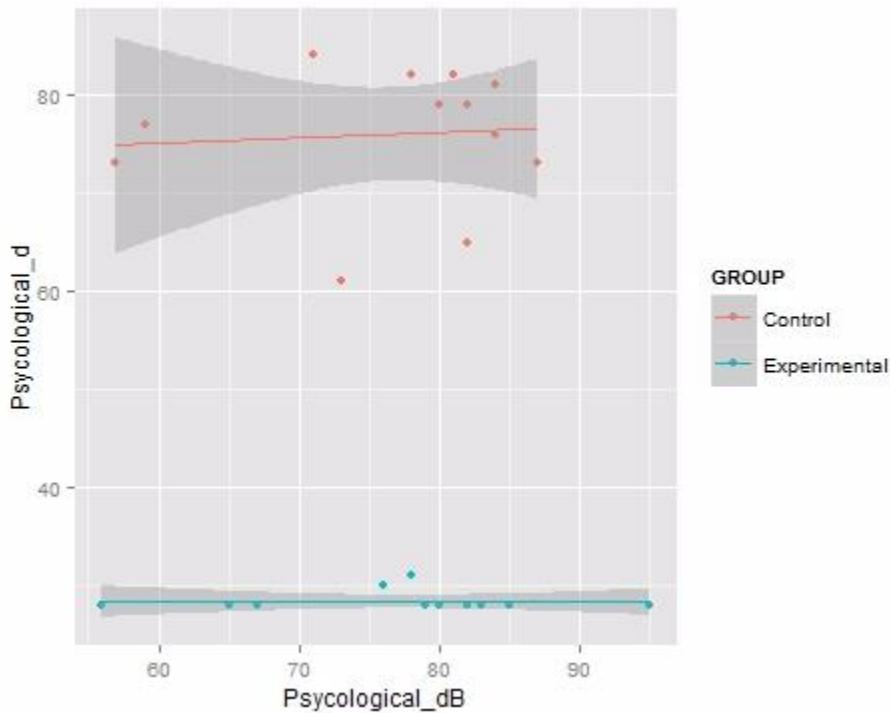
Table 9. Covariates of post-intervention GHQ

Source	SS	DF	MS	F	P	Np
Corrected Model	13586.436	2	6793.218	257.727	.000	.961
Intercept	946.376	1	946.376	35.904	.000	.631
GHQ B	1.394	1	1.394	.053	.820	.003
Group	13558.104	1	13558.104	514.379	.000	.961
Error	54.937	21	2.616			
Total	5171.000	24				

Group = Intervention + Control, GHQ B = General Health Questionnaire at baseline, R Square = .949 (Adjusted R Squared = .941)

The effect of the SCSi on the GHQ is depicted on graph 2 on page 108. Psychological dysfunction reflected by the GHQ post intervention among the experimental group was more significantly low compared with the control group. This shows the SCSi programme was very effective in reducing psychological dysfunction.

Graph 2. Distribution of GHQ at pre- and post-intervention



Psychological_dB = GHQ at baseline (pre intervention), Psychological_d = GHQ at post intervention.

Group was found to be statistically significant with regard to somatic complaints at post-intervention, implying that the type of group (intervention or control) participants belonged to had an effect on somatic complaints at post-intervention ($p < 0.001$). However, somatic complaints at baseline were insignificant with somatic complaints post-intervention. There was no difference in the effect of groups on post-intervention somatic complaints when interaction between the somatic complaints and the groups was considered (see table 10 on page 109).

Table 10. Covariates of somatic complaints (SC) after intervention

Source	SS	DF	MS	F	P	Np
Corrected Model	717.563	2	358.782	85.235	.000	.890
Intercept	138.489	1	138.489	32.901	.000	.610
SCB	2.521	1	2.521	.599	.448	.028
Group	717.271	1	717.271	170.402	.000	.890
Error	88.395	21	4.209			
Total	4581.000	24				

Group = Intervention + Control, SCB = Somatic Complaints at baseline, R Square = .949 (Adjusted R Squared = .941)

Results indicated that group was statistically significant with anxiety at post-intervention, indicating that the type of group (intervention or control) participants belonged to had an effect on somatic complaints at post-intervention ($p < 0.001$). However, anxiety at baseline was insignificant with anxiety post-intervention. There was no difference in the effect of groups on post-intervention anxiety when interaction between anxiety and the groups was considered (see table 11 on page 110).

Table 11. Covariates of anxiety after intervention

Source	SS	DF	MS	F	P	Np
Corrected Model	888.167	2	444.083	130.127	.000	.925
Intercept	57.888	1	57.888	16.963	.000	.447
ANX B	.000	1	.000	.000	.994	.000
Group	851.286	1	851.286	249.447	.000	.922
Error	71.666	21	3.413			
Total	5068.000	24				

Group = Intervention + Control, ANX B= Anxiety at baseline, R Square = .949 (Adjusted R Squared = .941)

Results revealed that group was significant statistically with regard to social functioning at post-intervention, inferring that the type of group participants belonged to had an effect on social functioning at post-intervention ($p < 0.001$). Nonetheless, social functioning at baseline was insignificant with social functioning post-intervention. There was no difference in the effect of groups on post-intervention social functioning when interaction between the social functioning and the groups was considered (see table 12 on page 111).

Table12. Covariates of social functioning post intervention

Source	SS	DF	MS	F	P	Np
Corrected Model	876.114	2	438.057	193.623	.000	.949
Intercept	132.802	1	132.802	58.699	.000	.737
SF B	.072	1	.072	.032	.860	.002
Group	854.638	1	854.638	377.753	.000	.947
Error	47.511	21	2.262			
Total	5217.000	24				

Group = Intervention + Control, SF = Social Functioning at baseline, R Square = .949 (Adjusted R Squared = .941)

The ANCOVA used to determine the predictors of severe depression indicated that group was statistically significant with regard to severe depression at post-intervention (refer to table 13 on page 112). The results demonstrated that the type of group (intervention or control) participants belonged to had an effect on severe depression at post-intervention ($p < 0.001$). Severe depression at baseline was thought insignificant with severe depression post-intervention. There was no difference in the effect of groups on post-intervention and severe depression when interaction between severe depression and the groups was considered. Given the results, hypothesis three was therefore accepted.

Table 13. Covariates of severe depression at post-intervention

Source	SS	DF	MS	F	P	Np
Corrected Model	929.021	2	464.511	177.562	.000	.944
Intercept	58.484	1	58.484	22.356	.000	.516
SD B	3.980	1	3.980	1.521	.231	.068
Group	911.958	1	911.958	348.601	.000	.943
Error	54.937	21	2.616			
Total	5171.000	24				

Group = Intervention + Control, SD = Severe at baseline, R Square = .949 (Adjusted R Squared = .941)

CHAPTER SIX

6. DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

This chapter serves as a final part of this dissertation. Primarily the chapter focuses on the discussion and interpretation of the major findings, conclusions and recommendations.

6.1. Discussions

The aim of this study was mainly to determine HIV and AIDS stigma experiences and psychological functioning among PLWHA, and to tailor an HIV and AIDS stigma and psychological dysfunctions reduction intervention programme. This was a two-in-one study that comprised two phases. Phase I was baseline assessment to determine stigma experiences as well as to determine psychological functioning among PLWHA. Phase II focused on tailoring, implementing HIV and AIDS stigma and psychological dysfunctions reduction intervention programme, and the determination of the effectiveness of the intervention programme. The study employed the cross-sectional design for phase I and pre-test post-test design for phase II. The results confirmed one and partially accepted two of the three hypotheses tested. Below the findings are discussed and recommendations are made.

Hypothesis one: There will be differences between PLWHA and PLWHPT on stigma experiences and psychological functioning, with PLWHA experiencing more stigma and psychological dysfunction than PLWHPT.

Results of the study reveal that PLWHA experience HIV and AIDS stigma (significantly more enacted over other stigma dimensions,) relative to PLWHPT. This finding is consistent with other previous studies whereby PLWHA reported higher incidence rates of stigma experiences than people with other chronic conditions (Crawford, 1996; Corrigan et al., 2000; Mak, et al., 2007; Idemudia & Matemela, 2012; dos Santos et al., 2014). This finding perhaps might have not been anticipated, considering the vigorous global state of HIV and AIDS educational programmes that have already been put in place with the rationale of combating stigma. But the present study reveals that HIV and AIDS stigma still prevails. This implies that stigmatising tendencies cannot be simply be inferred to lack of HIV and AIDS knowledge. This claim has been asserted by findings of the studies by Maughan-Brown (2010) and Wong (2013) who found that stigmatising attitudes were not associated with poor HIV knowledge, indicating that people still stigmatised PLWHA regardless of the adequate knowledge they have about the illness.

The results of this study can also be attributed to the fact that HIV and AIDS is viewed more from a moralistic than from a medical perspective. As it is documented that the most common mode of transmission in South Africa is mostly through heterosexual sex (UNAIDS & WHO 2013), the explanation of the present finding could be based on the sexual immorality associated with HIV and AIDS transmission. Understanding of immorality as the cause of HIV and AIDS enables the stigmatisers to distance themselves from sufferers (Grodensky et al., 2015), manifesting as enacted HIV and AIDS stigma, where the stigmatisers link sex to sin and sin to sex (Wangen, 2010).

Research confirm this assertion where it has been found that if it is known that an individual has contracted HIV through socially deviant behaviours such as multiple sex partners, homosexual sex, or injection drug practices, the individual is more stigmatised with more hostile reactions (Herek et al., 2003). Relative to other medical illnesses, HIV and AIDS is therefore perceived as an immoral illness whose bearer is discredited and viewed as tainted. These perceptions as a result precipitate stigmatising enactments. This notion is consistent with other research findings (Maulana, Krumeich, & Van Den Borne, 2009; Muoghalu & Jegede, 2013).

Also, the implication of high enacted stigma experiences in this study can further be explained with reference to Perloff's (2001) instrumental and symbolic stigma conceptualisation, as well as to the magical law of contagion model. Arising from the instrumental stigma perspective, as instrumental stigmatisation occur as a result of a perceived threat to an individual's health that produces a negative attitude toward an individual who is perceived to be the threat, the present finding may imply that stigmatisers perceived that being around PLWHA is a threat to their wellbeing; as a result they discriminate against them to avoid HIV contagion. Explaining the finding from symbolic stigma perspective, as symbolic stigma occurs due to the association made between the stigmatised individual with negative attitudes towards the associated stigmatised symbol (Perloff, 2001), PLWHA are therefore stigmatised on a metaphorical level due to the symbols attached to the HIV illness.

These are aspects such as prejudices associated with behaviours linked to HIV and AIDS transmission such as sexual immorality, promiscuity, homosexual sex, injecting drug use, sex work, etc., that perpetuate HIV and AIDS stigma enactments.

Furthermore, the results can be explained from the magical law of contagion (Rozin et al., 1992) and disease avoidance stigmatisation model (Oaten et al., 2011). The disease avoidance stigmatisation model posits that an illness that is known or viewed as contagious evokes fear of contagion and triggers avoidance. Also, according to the magical law of contagion, the fact that scientists globally are still battling without success to find the cure for the HIV virus, might also suggest that there are still other modes of HIV transmission that might be discovered later, or that certain contacts with PLWHA which are said not to transmit the virus may later be discovered to be routes of transmission. Therefore, the stigmatisers tend to exercise caution about personal vulnerability manifested as enacted HIV and AIDS stigma, hence the present finding.

The underpinning of this finding can further be explained in relation Goffman's (1963), Attribution (Heider, 1958), and Social Identity (Tajfel, 1981) theories alluded to earlier on in chapter two. Postulating from Goffman's stigma theorization, PLWHA may be viewed as possessing a tainted, tarnished character and discreditable mark of deviance from societal normalcy, resulting in enactments of stigma.

Linking with attribution theory postulation, the discreditable mark of deviance (HIV positive status) borne could have been attributed to internal controllability causal attributions. That is, PLWHA could be perceived to be blameworthy for their HIV positive mark of deviance, where they are regarded as personally responsible for their infection, producing hostile reactions and stigmatising behaviours.

With reference to social identity theory, the perception of PLWHA as possessing self-induced tarnished characters is viewed as spoiled identity. The spoiled identity pronounces deviance from societal and in-group norms. Therefore PLWHA could have therefore been outcast and discriminated against, with the in-group striving to maintain positive social identity and to protect their wellbeing manifested as enacted HIV and AIDS stigma.

Lower experience of internalised and perceived stigma were reported in this population relative to PLWHPT, hence hypothesis one was partially accepted. The lower experience of internalised and perceived HIV and AIDS could imply that participants have accomplished a sense of self-acceptance, positive self-concept and increased self-compassion, which serve as protective factors against such stigma. This claim is supported by research findings (for example, Emlet et al., 2011; Block, 2009; Neff, 2003). This finding is however in contrast with the results of a South African study by Gilbert and Walker (2009), where high levels of internalised and perceived HIV and AIDS stigma experiences were reported by their participants.

With regard to inter-association between the stigma dimensions, enacted stigma was found to be positively associated with perceived HIV and AIDS stigma. This might be due to the fact that the actual stigma enactment experiences predisposed participants to anticipate further stigmatisations. Therefore perceptions of stigma within this population may be due to participants' exposure to increased enacted stigma. Although conducted among non-adults, a similar result was found in a study conducted by Chibanda et al. (2014), where enacted stigma was found to aggravate the experience of perceived HIV and AIDS stigma.

Also, a negative relationship between internalised and enacted HIV and AIDS stigma was found in the present study. That is, enacted HIV and AIDS stigma decreased with increased experiences of internalised HIV and AIDS stigma. There is, however, a dearth of literature brought to the attention of the researcher that is consistent with this finding. Nonetheless, the explanation of this finding may be inferred to disclosure related issues. This could be due to the fact that individuals with internalised stigma experience might perhaps have not disclosed their status to anyone, resulting in lower enacted stigma. The relationship between internalised HIV and AIDS stigma and non-disclosure has been established by results of a study by Tsai et al. (2013), where internalised stigma was found to be associated with non-disclosure of HIV-positive status.

PLWHPT were used as controls for baseline establishment of stigma and psychological dysfunction experiences relative to PLWHA, therefore the results cannot be ignored. The study findings revealed a rather uncommon phenomenon with regard to this population. In this study, PLWHPT experienced significantly more internalised and perceived stigma. Regardless of hypertension being perceived as a silent killer (Kaunda, Menon, & Ngoma, 2012), non-communicable chronic disease (Okwuonu, Emmanuel, & Ojimadu, 2014) with debilitating effects (Ivarsson et al., 2015), there is however a scarcity of literature on stigmatising behaviours surrounding the condition. This finding might be due to the commonly attributed lifestyle related aetiological factors for the condition, such as being overweight/obesity or heavy alcohol use (Maredza et al., 2016) to name a few. Therefore PLWHPT may perceive themselves as personally responsible for their illness and anticipate stigmatisation from others as well. Empirical evidence to support this claim is however non-existent.

With regard to psychological dysfunctions, the study results indicated that PLWHA experienced generally more psychological dysfunction than their hypertensive counterparts. The finding is consistent with results of a South African study by Idemudia and Matamela (2012), where psychological dysfunctions were found to be more common among PLWHA than (in their case) cancer patients. Also, a positive relationship between HIV and AIDS stigma and psychological dysfunction was revealed by findings of the current study. That is, increased psychological dysfunctions were evident with increased HIV and AIDS stigma experiences in this population. A wide base of research evidence exists that support this result (Akena, Musisi, Joska, & Stein, 2012; Bhatia & Munjal, 2014; Freeman, Nkomo, Kafaar & Kelly, 2008; Kinyanda, Hoskins, Nakku, Nawaz, & Patel, 2011; Nachega, Morroni, Zuniga, Sherer, & Beyrer, 2012; Relf & Rollins, 2015; Su et al., 2013; Sun, Wu, Qu, Lu, & Wang, 2014, Wang et al., 2012). Relative to other stigma dimensions, enacted HIV and AIDS stigma demonstrated significant direct relationship with psychological dysfunction. In contrast, in their study Mak et al. (2007), found that internalised HIV and AIDS stigma was found to have had a negative impact on their population's psychological wellbeing.

Anxiety, depressive symptoms and social dysfunction were the most significantly experienced psychological dysfunctions by PLWHA in the current study. This finding is supported by South African research findings (Kagee & Martin, 2010; Nyirenda, Chatterji, Rochat, Mutevedzi & Newell, 2013) as well as non-South African studies (Nacher et al., 2010, Strodl, Stewart, Mullens, & Deb, 2015).

Peltzer and Ramlagan (2011) similarly found high levels of severe depressive symptoms in their large cohort study in KwaZulu-Natal, South Africa. In further agreement, Schumacher et al. (2012) found that comorbidity between anxiety and depressive symptoms in PLWHA was found to be high in their population. This finding may be attributed to stigma surrounding the HIV and AIDS condition.

The increased depressive and anxiety symptoms in this population can also be explained with reference to the terror management theory (discussed in chapter 2), which postulates that the human determination to stay alive as opposed to the consciousness of the inevitability of death has the power to produce intense fear of death evoking feelings of existential anxiety (Becker, 1973). The incurability of HIV and AIDS, the fatality knowledge, reduced life expectancy secondary to ill-health therefore precipitate anxiety and depression in PLWHA. The state of existential anxiety consequently results in poor psychological functioning for PLWHA. Greenberg (2012) ascertains this inference.

Study findings also indicate social dysfunction among PLWHA. This is most likely to be due to stigma, where participants could have resorted to self-isolation, social withdrawal and social avoidance as coping mechanisms resulting in social dysfunction. This assumption is supported by the findings of studies by Judgeoa and Moalusi (2014); Varni, Miller, McCuin and Solomon (2012), where disengagement and social isolation, even though maladaptive, were employed as coping mechanisms to cope with HIV and AIDS stigma, particularly enacted and perceived. This finding of the current study is in further agreement with several other research findings where social dysfunction was found among the PLWHA population (Enriquez, Lackey, & Witt, 2008; Grov et al., 2010).

Audet, McGowan, Wallston and Kipp (2013) similarly found that, owing to stigma, a larger proportion of their participants (75%) reported self-isolation from friends, families and community members. The majority of the participants reported reluctance to develop new friendships, to engage fully in their communities, and in the worst cases, seldom left their home.

With regard to hypertension, there is evidence which suggests a negative relationship between hypertension and poor psychological functioning (Cho et al., 2011). PLWHPT were found to experience more somatic-related complaints over other dimensions of the GHQ relative to PLWHA. Several other studies concur with this finding (Kaunda et al., 2012; Khaw, Hassan, & Latiffah, 2011; Saleem, Hassali, & Shafie, 2012; Trevisol, Moreira, Fuchs, & Fuchs, 2012). This could be as a result of the physical manifestation of hypertension symptomatology, which subsequently affects their psychological state (Hamer et al., 2010).

Due to increased prevalence of older PLWHA following increased life expectancy owing to ART (Emlet et al., 2015; UNAIDS, 2013), exploring the relations of age variations with HIV and AIDS stigma is vital. The present study found a significant inverse relationship between age and enacted HIV and AIDS stigma. That is, enacted HIV and AIDS stigma decreased with increased age. The study established that the older participants were, the less the stigmatising experiences. That is, increase in age did not predict HIV and AIDS stigma. This can perhaps be attributed to the fact that older people in this population were not subjected to internal controllability casual attributions, i.e. they might have been considered innocent victims of HIV and AIDS and not regarded as blameworthy for their HIV infection.

As it has been alluded to, PLHWA whose infection is perceived not to emanate from perceived immoral related activities are less likely to receive more hostile reactions (Herek et al., 2003). The HIV infection of older participants in this study might not have been attributed to acts of immorality relative to younger participants, but rather from a victim point of view such as caring for sick family members and significant others. This view is supported by the findings of South African studies (Ogunmefun, Gilbert, & Schatz, 2011; Schatz & Ogunmefun, 2007), where it was found that older South Africans, predominantly women, were found to be mostly care providers for the HIV and AIDS ill, both adults and children. Another South African study by Kuo, Cluver, Casale and Lane (2014) further attested to this notion. Their findings highlighted even further that these adult care givers mostly present with poor psychological functioning following caring for others with HIV and AIDS. Thus, the HIV-positive status of such individuals may therefore elicit feelings of sympathy more than hostility and discriminatory behaviours.

On the other hand, the increased stigma experiences of the younger participants could be due to personal controllability causal attributions, where they are perceived as blameworthy and deserve their infection. The results ascertain that young age predicted HIV and AIDS stigma enactments in this population. The innocent/guilty notion is ascertained by Wangen (2010) who postulates that another manner of classifying PLHWA experiences in relation to HIV and AIDS stigma is that of innocent versus guilty. The route of transmission may determine if an individual is perceived as guilty (e.g., acquired the virus through, for example, unprotected sex, drug use, prostitution, etc.) or innocent (e.g., blood transfusions, mother-to-child-transmission, or caring for a sick person).

Research findings on the relationship between age and HIV and AIDS are somewhat inconsistent. In partial agreement, such inverse relationship was found by Emler et al. (2015). That is, decreased level of stigma with increased age was noted. However, unlike in the present study, their participants experienced less internalised over enacted HIV and AIDS stigma with increased age. They argued the pattern of their finding with a premise that although encounters with prejudice and discrimination (enacted) might not lessen with age, it is possible that the overall internalisation of those enacted stigma experiences may.

Several studies found results in contradiction with the present study. A positive relationship between age and HIV and AIDS stigma is commonly found. Older PLWHA were found to experience more HIV and AIDS stigma than their younger counterparts due to layering phenomenon or ageism stigma outlined earlier in the literature review, where individuals are stigmatised based on their age too (Cahill & Valadéz, 2013; Grodensky et al., 2015; Kinyanda et al., 2014; Logie & Gadalla, 2009; Storholm et al., 2013; Visser et al., 2009). Exploring further in terms of the stigma dimensions, Grodensky et al. (2015) found a positive relationship between age and perceived stigma in their study. It was found that the older the participants were, the more they anticipated stigmatising attitudes. In contradiction to both the present study as well as other findings stipulated by other researchers, Wagner et al. (2010) and Wolitski et al. (2009) found no relationship between age and HIV and AIDS stigma.

With regard to duration of diagnosis the present study found no significant relationship between HIV and AIDS stigma and duration of diagnosis. Thus, duration of diagnosis did not predict HIV and AIDS stigma. However, duration of diagnosis was found to have a somewhat weak inverse relationship with enacted stigma, suggesting that the longer the participants have been living with HIV and AIDS diagnosis, the less likely are experiences of enacted stigma. This could be attributed to the benefits of ARV treatment where PLWHA's deviancy in terms of Goffman's body abominations diminishes.

With the roll out of ARVs, PLWHA are able to lead normal healthy lives, whereby the stigmatisers' cognitive schemas of HIV and AIDS being a killer disease get invalidated, resulting in reduced incidences of stigma enactments. However there are no studies to support this assumption. Contradictorily, a positive relationship was found between duration of diagnosis and HIV and AIDS stigma by Igumbor et al. (2012) and Côté et al. (2015), where a longer duration of diagnosis was associated with increased stigma enactments.

With regard to psychological dysfunction, no significant relationship was found with duration of diagnosis and psychological dysfunctions. That is, duration of diagnosis did not predict psychological dysfunctions. Similarly, Obadeji et al. (2014) in their study conducted in Nigeria where they determined the prevalence and predictors of depression among PLWHA, their results revealed no association between duration of diagnosis and depression.

In contrast to the present results with regard to psychological dysfunctions, a positive relationship between longer duration of diagnosis and increased psychological dysfunction was noted in other studies, for example studies conducted by Igumbor et al. (2012) and Côté et al.,(2015). PLWHA were found to experience increased symptoms of depression and anxiety with longer duration of diagnosis.

The study results revealed significant differences between PLWHA and PLWHPT at baseline assessment with regard to experiences of HIV and AIDS stigma and psychological dysfunction. PLHWA significantly reported more experiences of enacted stigma and psychological dysfunction at baseline than their hypertensive counterparts, while significantly higher levels of internalised and perceived stigma were recorded for PLWHPT. These baseline results informed the tailoring of the intervention (SCSI) programme.

Post the SCSI intervention, assessment indicated statistically significant difference between HIV and AIDS stigma experiences and psychological dysfunction, i.e., at post-test the experimental group (intervention exposed) reported reduced stigma and diminished psychological dysfunctions. This finding confirms the effectiveness of the SCSI intervention programme in reducing HIV and AIDS stigma and enhancing psychological functioning. This outcome can be attributed to the psycho-education and the skills training part of the SCSI programme, whereby participants became empowered with the knowledge and skills to use to counteract HIV and AIDS stigma. The SCSI significantly demonstrated its effectiveness as well in reducing psychological dysfunctions of the participants. High levels of depression, anxiety and social dysfunction among PLWHA significantly diminished following the SCSI programme.

6.2 Conclusion

The current study demonstrated that HIV and AIDS stigma is still pervasive and continues to negatively impact the psychological functioning of PLWHA. Among the three stigma dimensions (internalised, perceived and enacted), enacted HIV and AIDS stigma was significantly experienced by PLWHA relative to PLWHPT. Relatively, PLWHPT significantly experienced more internalised and perceived stigma.

The study essentially highlighted that PLWHA experienced relatively more psychological dysfunctions than their hypertension counterparts. Enacted HIV and AIDS stigma was found to significantly predict psychological dysfunctions. Enacted HIV and AIDS stigma had a significant direct positive relationship with psychological dysfunctions (global GHQ and all its dimensions: somatic complaints, anxiety, social functioning, and severe depression). Enacted HIV and AIDS stigma had a significant direct negative relationship with age, and non-significant direct negative relationship with duration of diagnosis. Age was found to have significant direct negative relationship with psychological dysfunctions. Duration of diagnosis had a non-significant direct negative relationship with psychological dysfunctions.

The SCSi demonstrated effectiveness in HIV and AIDS stigma, as well as psychological dysfunction, reduction. The SCSi was found to be effective in empowering participants with efficient skills to deal with HIV and AIDS stigmatising enactments, and in enhancing psychological functioning.

6.3 Limitations

Conclusions from this study about HIV and AIDS stigma and psychological functioning among PLWHA should be interpreted taking cognisance of the limitation of the representativeness of the study population. Generalisation to all South African populations cannot be asserted, as the study was conducted only in Limpopo Province, and the sampling was not representative enough of all regions of South Africa.

The determination of psychological dysfunction using GHQ should also be interpreted with caution as the GHQ is not a diagnostic instrument, and can only be used to deduce symptoms of emotional distress not diagnose precise psychological disorders.

6.4 Recommendations

Collaborative intervention programmes at the macro level by relevant HIV and AIDS stakeholders and policy makers that are aimed at the general population (those not infected with HIV or suffering from AIDS) to reduce HIV and AIDS stigma, particularly enacted, are indicated.

Taking into cognisance the adverse effects of psychological dysfunctions on PLWHA, as well as on treatment and prevention of HIV and AIDS, it would be beneficial to integrate psychological interventions into the routine treatment programmes for PLWHA, for treatment and prevention of the development of psychological dysfunctions. This will help in prevention, and/or early detection of psychological dysfunctions symptoms before they affect treatment compliance and further HIV transmission, i.e., break the psychological dysfunctions-induced vicious cycle of HIV transmission.

6.5 Implications for Future Research

There is a need to empirically determine contextual underlying factors that still maintain stigmatising behaviour in the general population (the non-HIV-infected) regardless of the widespread HIV and AIDS education programmes. This is informed by the high reports of experiences of enacted stigma over other stigma dimensions.

The significant indirect relationship between age and enacted HIV and AIDS stigma in this population is inconsistent with most other research findings; it would be worthwhile to empirically establish the factors behind the nature of this relationship.

Since the SCIS has proven effective in stigma and psychological dysfunctions reduction, it can therefore be replicated and be used in other contexts, especially because of the scarcity of this kind of intervention in South Africa.

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APPENDICES

APPENDIX A

North-West University Ethical Approval

APPENDIX B

Department of Health Provincial Ethical Approval

APPENDIX C

PARTICIPANTS CONSENT FORM

**Title of the Research: Stigma, Psychological Functioning and Efficacy of Stigma
Reduction Training among People Living with HIV and AIDS in Limpopo Province**

- The purpose of the research has been explained to me in detail, and I choose to participate in the research.
- I understand that my participation in this research is voluntary
- As my participation in this research is voluntary, withdrawal to participate later on will involve no penalty.
- I have the right not to answer any question I feel uncomfortable about, or withdraw at any stage without any Impact on me and services rendered to me in this hospital.
- I agree that some of my comments or statements may be anonymously quoted in the report.
- I understand that if I need further clarifications I can contact the researcher.

Declaration

I agree to participate in this research

Signature (Participant) _____

Date _____

9. It is my fault to get this illness	1	2	3	4
10. It is a matter of bad luck	1	2	3	4
11. This is a punishment of bad behaviour	1	2	3	4
12. I feel bewitched	1	2	3	4
13. In interaction with other I feel uncomfortable	1	2	3	4
14. I think less of myself	1	2	3	4
15. People have a right to be afraid of me	1	2	3	4
16. I feel less attractive	1	2	3	4
17. I can teach others about life	1	2	3	4
18. I can look after children	1	2	3	4
19. I deserve praise for handling this illness	1	2	3	4
20. I understand if people reject my friendship	1	2	3	4
21. Others do not drink from the same tap as me	1	2	3	4
22. Employers would not hire me	1	2	3	4
23. Neighbours would not like me living next door	1	2	3	4
24. People do not sit next to me in public transport	1	2	3	4
25. I deserve respect	1	2	3	4
26. I am no different				

Perceived Community Stigma

27. People with this illness should be ashamed	1	2	3	4
28. They deserve the illness	1	2	3	4
29. The illness is their own fault	1	2	3	4
30. The illness is a matter of bad luck	1	2	3	4

31. The disease is a punishment for bad behaviour				
32. People with HIV are bewitched	1	2	3	4
33. Most people feel uncomfortable interacting with someone with HIV	1	2	3	4
34. Most people think less of someone with HIV	1	2	3	4
35. Most people are afraid to be around someone with HIV	1	2	3	
36. Most people are not attracted to someone with HIV	1	2	3	4
37. They can teach others about life	1	2	3	4
38. It is not safe for them to look after children	1	2	3	4
39. People with this illness deserve praise	1	2	3	4
40. People would reject my friendship	1	2	3	4
41. People would not drink from the same tap as me	1	2	3	4
42. Employers would not hire me	1	2	3	4
43. Neighbours would not want someone with HIV living next door	1	2	3	4
44. People would not sit next to someone with HIV in public transport	1	2	3	4

Enacted Stigma

1 = No experience 2 = Experience 3 = A lot of experience

48. I have lost friends because of this illness	1	2	3
49. I felt hurt by other people's reactions	1	2	3
50. People do not touch me	1	2	3

51. People do not want me around their children	1	2	3
52. People do not want me to come to their houses.	1	2	3
53. I have been called bad names	1	2	3
54. I have been physical hurt	1	2	3
55. I have been threatened with death	1	2	3
56. My partner left me because of my diagnosis	1	2	3

SECTION C

We would like to know if you had any health complaints and how your health has been in general, over the last few weeks. Please answer ALL the questions by circling the answer which best applies to you. Remember that we want to know about the **PRESENT AND RECENT** complaints, not that you had in the past.

It is important that you try to answer to answer ALL the questions.

1 = Better than usual, 2 = Same as usual, 3 = Worse than usual 4, = Much worse than usual

1. Have you been feeling well and in good health?	1	2	3	4
2. Have you been feeling in need of good energizer?	1	2	3	4
3. Have you been feeling run down and out of sorts?	1	2	3	4
4. Have you been feeling that you are ill?	1	2	3	4
5. Have you been getting pains in your head?	1	2	3	4
6. Have you been getting a feeling of tightness or pressure in the head?	1	2	3	4
7. Have you been having hot or cold spells?	1	2	3	4
8. Have you lost much sleep over worry?	1	2	3	4

9. Have you been having feeling difficulty staying awake once you are in bed?	1	2	3	4
10. Have you been constantly under strain?	1	2	3	4
11. Have you been feeling edgy and short-tempered?	1	2	3	4
12. Have you been feeling been getting scared and panicky for no good reason?	1	2	3	4
13. Have you been finding everything getting on top of you?	1	2	3	4
14. Have you been feeling nervous and strung-up all the time?	1	2	3	4
15. Have you been managing to keep yourself busy and occupied?	1	2	3	4
16. Have you been taking longer to finish things you do?	1	2	3	4
17. Have you been feeling that overall, you were doing things well?	1	2	3	4
18. Have you been satisfied with the way you carry out tasks?	1	2	3	4
19. Have you been feeling that you are playing a useful part/role in things?	1	2	3	4
20. Have you been feeling capable of making decisions about things?	1	2	3	4
21. Have you been able to enjoy your normal day-to-day activities?	1	2	3	4
22. Have you been thinking of yourself as worthless?	1	2	3	4
23. Have you been feeling that life is entirely hopeless?	1	2	3	4
24. Have you been feeling that life is not worth living?	1	2	3	4
25. Have you thought of the possibility that you might make away with yourself?	1	2	3	4

26. Have you been finding that at times you could not do anything because your nerves were so bad? 1 2 3 4
27. Have you been finding yourself wishing you were dead and away from it all? 1 2 3 4
28. Have you been finding that the idea of taking your own life kept coming into your mind? 1 2 3 4

THANK YOU FOR TAKING PART IN THIS STUDY

APPENDIX E

HYPERTENSION AND PSYCHOLOGICAL FUNCTIONING QUESTIONNAIRE

Dear Sir/Madam

This study investigates stigma and psychological functioning among people living with hypertension. The results of this study will help in the development and formulation of intervention programme to alleviate stigma and enhance psychological functioning. There is no right or wrong answer. Your participation is highly appreciated.

SECTION A

File No: Name: Contact No:

Age:Gender: M/F

Marital Status: Married.... Never married Divorced Widowed.....

Home language:

Occupation:

Income:

Educational Level:

Residential Place:

Duration of Hypertension Diagnosis:

SECTION B

Read the following statements and please answer the questions as honestly as possible by circling the number of the answers that you agree with the most.

1=Strongly agree 2=Agree 3=Disagree 4=Strongly disagree

Internalised/Felt Stigma

- | | | | | |
|--|---|---|---|---|
| 7. I feel ashamed of having this illness | 1 | 2 | 3 | 4 |
| 8. I have done something to deserve this illness | 1 | 2 | 3 | 4 |

9. It is my fault to get this illness	1	2	3	4
10. It is a matter of bad luck	1	2	3	4
11. This is a punishment of bad behaviour	1	2	3	4
12. I feel bewitched	1	2	3	4
13. In interaction with other I feel uncomfortable	1	2	3	4
14. I think less of myself	1	2	3	4
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16. I feel less attractive	1	2	3	4
17. I can teach others about life	1	2	3	4
18. I can look after children	1	2	3	4
19. I deserve praise for handling this illness	1	2	3	4
20. I understand if people reject my friendship	1	2	3	4
21. Others do not drink from the same tap as me	1	2	3	4
22. Employers would not hire me	1	2	3	4
23. Neighbours would not like me living next door	1	2	3	4
24. People do not sit next to me in public transport	1	2	3	4
25. I deserve respect	1	2	3	4
26. I am no different				

Perceived Community Stigma

27. People with this illness should be ashamed	1	2	3	4
28. They deserve the illness	1	2	3	4
29. The illness is their own fault	1	2	3	4
30. The illness is a matter of bad luck	1	2	3	4

31. The disease is a punishment for bad behaviour				
32. People with Hypertension are bewitched	1	2	3	4
33. Most people feel uncomfortable interacting with someone with Hypertension	1	2	3	4
34. Most people think less of someone with Hypertension	1	2	3	4
35. Most people are afraid to be around someone with Hypertension	1	2	3	4
36. Most people are not attracted to someone with Hypertension	1	2	3	4
37. They can teach others about life	1	2	3	4
38. It is not safe for them to look after children	1	2	3	4
39. People with this illness deserve praise	1	2	3	4
40. People would reject my friendship	1	2	3	4
41. People would not drink from the same tap as me	1	2	3	4
42. Employers would not hire me	1	2	3	4
43. Neighbours would not want someone with Hypertension living next door	1	2	3	4
44. People would not sit next to someone with Hypertension in public transport	1	2	3	4

Enacted Stigma

1 = No experience 2 = Experience 3 = A lot of experience

48. I have lost friends because of this illness	1	2	3
49. I felt hurt by other people's reactions	1	2	3
50. People do not touch me	1	2	3

51. People do not want me around their children	1	2	3
52. People do not want me to come to their houses	1	2	3
53. I have been called bad names	1	2	3
54. I have been physical hurt	1	2	3
55. I have been threatened with death	1	2	3
56. My partner left me because of my diagnosis	1	2	3

SECTION C

We would like to know if you had any health complaints and how your health has been in general, over the last few weeks. Please answer ALL the questions by circling the answer which best applies to you. Remember that we want to know about the **PRESENT AND RECENT** complaints, not that you had in the past.

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2. Have you been feeling in need of good energizer?	1	2	3	4
3. Have you been feeling run down and out of sorts?	1	2	3	4
4. Have you been feeling that you are ill?	1	2	3	4
5. Have you been getting pains in your head?	1	2	3	4
6. Have you been getting a feeling of tightness or pressure in the head?	1	2	3	4
7. Have you been having hot or cold spells?	1	2	3	4
8. Have you lost much sleep over worry?	1	2	3	4

9. Have you been having feeling difficulty staying awake once you are in bed?	1	2	3	4
10. Have you been constantly under strain?	1	2	3	4
11. Have you been feeling edgy and short-tempered?	1	2	3	4
12. Have you been feeling been getting scared and panicky for no good reason?	1	2	3	4
13. Have you been finding everything getting on top of you?	1	2	3	4
14. Have you been feeling nervous and strung-up all the time?	1	2	3	4
15. Have you been managing to keep yourself busy and occupied?	1	2	3	4
16. Have you been taking longer to finish things you do?	1	2	3	4
17. Have you been feeling that overall, you were doing things well?	1	2	3	4
18. Have you been satisfied with the way you carry out tasks?	1	2	3	4
19. Have you been feeling that you are playing a useful part/role in things?	1	2	3	4
20. Have you been feeling capable of making decisions about things?	1	2	3	4
21. Have you been able to enjoy your normal day-to-day activities?	1	2	3	4
22. Have you been thinking of yourself as worthless?	1	2	3	4
23. Have you been feeling that life is entirely hopeless?	1	2	3	4
24. Have you been feeling that life is not worth living?	1	2	3	4

25. Have you thought of the possibility that you might make
away with yourself? 1 2 3 4
26. Have you been finding that at times you could not do
anything because your nerves were so bad? 1 2 3 4
27. Have you been finding yourself wishing you were
dead and away from it all? 1 2 3 4
28. Have you been finding that the idea of taking your own
life kept coming into your mind? 1 2 3 4

THANK YOU FOR TAKING PART IN THIS STUDY

APPENDIX F

STIGMA COPING SKILLS INTERVENTION (SCSI)

Stigma Stops Here



STIGMA
STOPS
HERE



Compiled By: Ms Modiba MW

INTERVENTION TEMPLATE

- The intervention is a combination of information based, skills building and psychotherapeutic/Counselling approach.
- Time: 60-90 minutes per session.
- After session 1 (group formation), each session start with the review of what was learnt in previous session.
- Facilitator: Clinical Psychologist

Session 1: Group Formation

Objectives of the session

By the end of this session:

- The group should have been established and group members ready for participation.
- Participants should be having an understanding of the aims of the intervention programme and how is going to be benefit them.
- Participants must be aware of their ethical rights.
- Participants should be familiar and be at ease with each other.

The session entails:

- Introduction of the purpose of the group.
- Setting ground rules.
- Rapport building with participants (use of ice breakers).
- Allowing participants to get to know each other.
- Explain selection criteria (how & why) participants are selected to participate
 - Selection is informed by baseline assessment results, those who are found to experience stigma are selected.
- Outline of ethical aspects to be observed, with special emphasis on confidentiality
- Outline of the course of the intervention programme.

- Duration of the programme.
- Aspects that will be covered.

Session 2: Identification of Stressors and Coping Mechanisms

Objective/s of the session:

By the end of this session:

- Participants will have vented out their distress in a safe and supportive environment.
- Participants will gain insight of their coping strategies (i.e. whether adaptive or maladaptive).

The session entails:

- Participants relating their personal experiences in relation to the stigma dimensions, with special emphasis on enacted more than the other stigma dimensions (informed by baseline results).
- Participants to be contained (those who can get emotionally distressed) as they relate their experiences.
- Participants to relate their coping strategies they use to cope with the stigma.

Session 3: HIV and AIDS Knowledge - Information Empowerment

Objectives:

By the end of this session participants will be able to:

- Understand basic facts and information about HIV and AIDS as a basis for dealing with stigma
- Explain how myths and misinformation about HIV and AIDS contribute to the development of stigma

The session entailed:

- Review of participants' HIV and AIDS, knowledge so as to establish their level of knowledge, so as to equip them with adequate information by asking the following questions written on a flip chart.
- **HIV/AIDS Basic Information:**
 - What is HIV?
 - What is AIDS?
 - Is HIV and AIDS the same thing?
- **Transmission Mode**
 - Will a person will get HIV by doing the following:
 - hugging an HIV positive person
 - shaking hands with an HIV positive person
 - sharing a glass of water with an HIV positive person
 - sharing a toilet with an HIV positive person
 - eating from same plate with an HIV positive person
 - sharing a bed with an HIV positive person
 - Semen & vaginal fluids during sexual intercourse
 - Contact with infected blood
 - Blood transfusion

- The questions are discussed amongst group members during the group.
- Psycho-education on HIV and AIDS basic information including transmission mode is thereafter to be provided by the facilitator.

Session 4: Communication Skills - Skills Empowerment

Objectives:

By the end of this session:

- Participants will be able to communicate in a healthy and effective manner.

The session entails:

- Empowering participants with healthy and effective communication patterns which comprised:
 - Listen carefully
 - Don't jump into conclusion, seek clarity from the speaker
 - Be clear, don't be circumstantial (make your feeling/thought are known)
- Homework to be given to practice the skill learnt

Session 5: Assertive Skills - Skills Empowerment

Objective/s:

By the end of this session participants will be able to assert themselves in an effective manner.

The session entails:

- Equipping participants with assertive skills which includes:
 - Participants learning differences between assertiveness and arrogance.
 - Participants learning how to stand their ground without being arrogant.
 - Participants learning under which circumstances they need to be assertive.

- Participants to role play amongst each other, practice the skill learnt under supervision of the facilitator.
- Homework to be practice the skill learnt.

Session 6: Cognitive Restructuring - Psychotherapeutic (CBT orientated)

Objective/s:

By the end of this session:

- Participants will be able to recognise the cognitive distortions that result in psychological dysfunctions, and know how to overcome them.
- Participants to experience reduced psychological dysfunctions.

The session entails:

Internalised HIV and AIDS stigma: Based on Goffman's (1963) postulation, the stigmatised tend to internalise the tarnished mark or label (from labelling theory postulation) (e.g. sexual immoral) put upon them by the stigmatisers, resulting in internalised stigma. This often manifests in the form of self-defeating thoughts and self-blame predisposing them to psychological. Such cognitive distortions that lead to internalisation of the stigma are therefore challenged and disputed. Perceived HIV and AIDS stigma: Due to the knowledge that PLWHA are perceived negatively and are as a result avoided, this knowledge precipitate perceived stigma among PLWHA. Mind reading cognitive distortions that lead to stigma perception and anticipation are challenged and disputed.

- Enacted HIV and AIDS stigma: Enacted stigma here is conceptualised from Goffman (1963), social identity theory, disease avoidance model, and magical law of contagion. Intervention involves reframing-providing/instilling alternative interpretations - (e.g. stigmatising attitudes to be viewed as lack of knowledge and as an indication of a need for more HIV and AIDS education.

Session 7: Stress management - Knowledge/ Information Empowerment

Objective/s:

By the end of this session participants will know how to manage stress in healthy manner.

The session entails:

- Providing psycho-education on healthy stress management strategies with a focus on the following:
 - Speak up, don't bottle up your feelings.
 - Don't allow petty things to upset you/ mind reading (e.g. people are laughing while you are approaching, don't assume they are gossiping about you.)
 - Hobbies/Distractions (Do something that interests you).
 - A daily dose of humour and laughter is excellent in combatting stress.
 - Exercise.
 - Have enough rest/sleep.

Session 8: Closure

Objective/s:

By the end of this session:

Participants will be able to recapitulate on the skills learnt during the entire programme.

Be equipped with the skills to deal with HIV and AIDS stigma and experience reduced psychological dysfunctions.

Part ways well with group members and the group terminated.

The session entails:

- Participants recapping aspects and skills learnt throughout the programme.
- Participants to be given a chance to bid each other farewell.
- Words of encouragement and well wishes in the fight against stigma and the significance for striving for better psychological functioning to be done as closing remarks and wrapping up the programme by the facilitator.

- Facilitator to sum up and terminate group.
- Administration of post-test by the facilitator.