CHAPTER 6

DISCUSSION OF RESULTS

6.1 INTRODUCTION

In this chapter, the researcher will present the discussion of the results and integration with the literature. The discussion will begin with a look at the experiences of being HIV-positive for all the women, and it will be followed by a discussion of the ways of coping with HIV employed by these women.

6.2 THE EXPERIENCE OF BEING HIV-POSITIVE

6.2.1 EXPERIENCES IN RELATION TO SELF

Those categories of experience that relate to the women's feelings about themselves as a result of being HIV-positive were considered for this theme.

After being diagnosed with HIV, the women went through different emotions. The initial reaction was shock and disbelief. It was very difficult for them to accept the fact that they were having the virus in their bodies.

Westbrook and Viey (1982) stated that anger, as a psychological reaction to the onset of chronic illness, is often generated by feelings of frustration associated with the illness. Feelings of anger dominated the responses the women gave. This anger seemed to be mainly directed at the people who were thought to be responsible for infecting the women. The difference in verbalising and admitting to these feelings of anger seemed to be related to the type of relationship between the women and the person who infected them. One of the women could not outwardly blame her present partner for infecting her, even if he was responsible. In cases of the person being a previous partner or the rapists as it was the case with one woman, it seemed easy to put blame without hesitation or looking for excuses for that person. Family members who were not thought to be supportive were also at the receiving end of anger.

When a person is diagnosed with HIV, they immediately think about death. From that moment, that person will also be grieving and mourning some loss, which can be loss of life associated with anticipation of death, or loss of time as a result of the now limited life span. In Martha's case, anger made it difficult to mourn the loss of her boyfriend, who she blamed for infecting her. Simos (1979) sees anger as an integral part of the grieving process. Hate feelings were found to be closely related to anger, with hate also being directed to people who were thought to have infected the subjects.

The emotional reactions also included feelings of self-blame and guilt at being infected. This type of emotional response is common in women, due to the common perception that if they are infected with HIV, they have to be promiscuous (Bennett, 1990). Guilt feelings stem from the thought of dying and leaving one's children behind. These feelings can account for much of the pain of the process of mourning (Simos, 1979). Martha's guilt feelings were mostly related to the perception that she has become a burden to her daughter, who is her only source of support.

Feelings of hurt were also prominent with the participants. Thinking about the children and what will eventually happen to them when their mothers are no longer alive, was very hurtful to the women. The thought of bringing shame to their families when the news becomes known to everybody also hurt. After being raped, Linda couldn't help thinking about that incident. She used to be very depressed whenever she thought about it, but she said lately, it no longer depresses her that much, it only hurts.

Apart from worrying about themselves and their health, these women said they worry about leaving their children behind as well. In cases where there is nobody to take care of the children after the parents have passed away, the children's well-being seemed to be the major thing in the mother's mind. Charlotte's feelings of worry stemmed mostly from her husband's condition, which seems to be getting worse daily. The fact that she also works far from home means that she spends most of her days worried, wondering if she'll find him still alive when she gets home in the evening. Financial factors play a huge role in these women's state of mind. Uncertainty about the future in a sense of not knowing how long they still have to live means they must start saving money for their children. In case of a person like Charlotte, the type of food they are supposed to eat also means proper budgeting in order to afford to cover everything. She has now become the sole breadwinner at home, yet, she spends almost all her salary on transport commuting to work and back.

There were references to sadness and depressed mood during the interviews. All the women did not seem to be depressed during the interviews. They however expressed feeling depressed at some stage or another since they were diagnosed. Two of the women were admitted and treated for depression at least three times since diagnosis, and they also attempted suicide at least twice before. Similar findings were reported by Katz (1997) and Kelly (1998). During these phases of depression they felt hopeless and helpless, and just wanted to end their lives thinking that they were going to die anyway. The knowledge of the facts about the virus and the progression of the disease helped them to understand that they can still live for a long time with the virus, as long as they take proper care of themselves.

Some women mentioned feeling worthless and ashamed of themselves soon after they were diagnosed. The reactions they receive from people further reinforce those feelings. At that stage, all they felt is that they were not worth anything.

People's perception of HIV somehow influences the way HIV infected people perceive themselves (Siegel *et al.*, 1998). The women seemed to be worried about the way they appear physically, trying to maintain weight in an attempt to remove attention from their physical appearance and suspicion about their HIV status. They therefore ensured that they eat enough to be able to retain their body weight. It was important to these women whether people can tell that they are HIV positive by merely looking at them.

6.2.2 EXPERIENCES IN RELATIONSHIPS WITH OTHERS

The themes discussed here relate to the way the women experienced their relationships with partners, members of their families, friends, and members of the public since they were diagnosed.

In the case of HIV-infection, it is important to recognise not only the powerful influence of the individual's immediate familial/social context, but also the broader impact of the larger social climate, and particularly the negative effects of the social stigma, fear of rejection and discrimination (Kaminsky, Kurtines, Hervis, Millon, Blaney & Szapocznik, 1989). The difficulty in sharing the diagnosis with partners was apparent from the women's experiences. It seemed easier if the partner knew about his own status already. In cases where the partners did not know, as it was with Martha, she feared telling him because she was afraid of being rejected.

The common perception from men seems to be that if a woman first tests HIV-positive, she must have contacted it from elsewhere (Paterson, 1996). In Romania, HIV-positive women who had multiple partners were apparently listed as prostitutes in official statistics (Bennett, 1990). When men became the ones who undergo HIV testing first, the women usually find themselves forced to forgive them and stay with them. Paterson (1996) is of the opinion that some women stay with such men because they are dependent on them financially and they sometimes have nowhere to go if they leave them.

Lusakulira (in Bennett, 1990) pointed out that in places like Zaire, HIV-positive women are always blamed for infecting their husbands even though those women suspected that their partners had transmitted the virus to them. In this study, two women are still with the partners they were with before they were diagnosed, one woman's partner left her two years after diagnosis, and the other one has not told anyone she'd been with since the diagnosis about her status.

These difficulties in the relationships seem to be brought about by the changes the diagnosis brings into the way the couples have to live their lives (Walker, 1991). Women mentioned the fact that suddenly they must always have sexual intercourse with a condom, which is difficult in a marriage or a long-standing relationship, where partners didn't use condoms before. The women said they insist on using condoms to protect themselves from re-infection, with an exception of one, who has an agreement with her partner not to use condoms. The agreement had to be accompanied by the commitment from both partners to never have sex outside their relationship.

People living with HIV are better able to live with their condition when they develop or maintain ties with friends, family, and other people living with the virus (Groomes, 1998). The participants' families mostly reacted with shock and hurt. The way they treated the participants ranged from total support to rejection of the HIV-infected person. Rejection from family members hurts most, since they are the people who are thought to be supposed to accept them unconditionally. The decision to disclose the status to family members depended on how much the women trusted their families. In cases where the women felt that they don't trust somebody enough, they kept their diagnosis a secret. Two of the women received love and total support from their families, one woman only told some family members and left others out because she didn't trust them enough to reveal her status to them. She however still got negative reactions from some of those she told. One woman's family rejected her and started treating her badly. She mentioned examples like her sister washing the cup she used to drink water with bleach.

The type of treatment the women received from their families determined the way they related to them thereafter. After Martha's family rejected her, she decided to stop visiting them, unless if it was really necessary. Loss of interpersonal contact, especially with significant people like family members, leaves a person with feelings of isolation (Manuel, Roth, Keefe & Brantley, 1987). This isolation that Martha experienced left her more worried about who is going to take care of her children when she is no longer around.

Although the women expressed their disappointment and hurt as a result of the treatment they got from others, some of them still felt that keeping the diagnosis a secret also contributed to feelings of isolation. They mentioned that when they were unable to talk to other people about their situation, they always felt like they really needed to talk or unload to somebody.

Those who told their friends reported to have experienced nothing but support from them. Being accepted seemed very important to all the women. Although they all feared being stigmatised if their status becomes known, they seemed not to have any problems with disclosure when and if they were ready.

One participant disclosed her status publicly by giving talks in colleges, technikons, and on television. Another participant is now able to tell people at her work place and in her neighbourhood, while two participants still felt that they were not yet ready to tell people outside their families. There was a general understanding that people who are ignorant about HIV are the ones who are making life miserable for people living with HIV. For the participants it seemed that society has concluded that HIV-positive women are promiscuous women or prostitutes.

Groomes (1998) reminded us of the difficulties people with HIV must face when they have to interact among hostile people who perceive them as morally responsible for bringing the disease forward. This perception doesn't help HIV-positive women; it only makes disclosure more difficult. Linda mentioned that she understands that she can't expect everybody to accept her the way she is, with her HIV status. This makes disclosure something she thinks one has to risk when one is ready, conceding that other people will accept and others will reject you.

The only way to remedy the situation described above is through education. The women seem to participate in educating others, each in her small way. They, however, think that not enough is being done to ensure that people become knowledgeable about HIV and AIDS. This experience seems to agree with Strebel's (1992) observation from the study that she conducted on women's disclosure of their HIV status. It was generally felt that there was not much awareness of HIV in the community, which Strebel suggested is closely tied to the wider process of denial about the presence of HIV/AIDS in South Africa (Strebel, 1992).

Although Martha is not yet ready to disclose her status, she said she reads about HIV a lot and teaches her children what they have to know about it. Linda has started telling her colleagues about her condition and educating those who need to know the facts about it. Since Charlotte used to help at the Red Cross, she felt she had the knowledge other people needed about the disease. Although she didn't tell them about her own status, she helped women come to terms with their positive status. She sometimes felt guilty; as if she is deceiving other people, but she said she has a lot to deal with now, with her husband being terminally ill. Being a caregiver to him almost takes all her time and energy. Biegel, Schultz and Sales (1991) pointed out that caregivers to chronically ill individuals also need support and they are often faced with the problem of coping with the lack of support. Charlotte does not have anyone to help her care for her husband, except the husband's brother, who is not always around due to work.

6.3 COPING

According to Ramsey (1989), coping strategies are generally viewed as ways of responding that transcend different situations. Coping is not thought of as a single act but as a constellation of thoughts and acts. This is the reason Lazarus and Folkman (1984) maintained that individuals should not be seen in terms of coping and non-coping but as demonstrating varying degrees of distress and coping over time as they are faced with different situations.

Efforts to change the stressful situation, thus controlling distress, are usually differentiated from responses that alter the cognitive appraisal of stress (Pearlin & Schooler in Holahan & Moos, 1987). Holahan and Moos (1987) mention two coping responses, namely active/approach and avoidance strategies. Style of coping with stress also predicts levels of depression, anxiety, and distress among HIV-positive individuals (Kelly, 1998).

Lazarus and Folkman (cited in Essau & Trommsdorf, 1996) identify two major functions of coping namely, problem focused coping and emotion focused coping. These two functions are explained in section 3.1.3.3. The ways in which the women in the study cope with HIV, will be discussed using the two above-mentioned functions of coping.

Looking at the results of the study, it was clear that the women did not use a single and specific way of coping with their situations. Different ways of coping were used at different stages of experience, like after the initial diagnosis and the time of the interview.

6.3.1 PROBLEM-FOCUSED COPING

This type of coping involves taking a direct action with the purpose of changing the situation through, among other things, decision making, making a plan of action and fighting for what one believes in (Folkman & Lazarus, 1985).

Paterson (1996) reported that women in Rio de Janeiro are involved in educating their communities about living with HIV, using themselves as examples. These women reported that talking about their condition and educating others help them feel better about themselves and cope with the disease. All the women in the study are somehow involved in educating other people about HIV and experiences a person who is HIV-positive goes through. They reported to find talking about the disease, even without disclosing that they are HIV-positive themselves, makes them feel that they are contributing something towards the fight against the disease. Some women have become brave enough over the period since the diagnosis to disclose their status to people outside their families.

Reading and learning about HIV and AIDS most likely helped the women to get a feeling of control over the disease. For example, Martha said that having an idea of what to expect more or less prepares her and makes her know what to do when something happens. This feeling of control is associated with being able to take charge of their lives and live the way they want to live. Actions like making sure that they always use condoms when they are engaged in sexual intercourse in order to avoid infecting others and getting themselves re-infected, are ways of coping with their situation. They also take care of what they eat and keep their bodies fit by exercising regularly.

Taking care of themselves also means that the women have to seek medical help when necessary. They all reported that they make sure that they consult the doctor and seek medical help whenever they don't feel well. They also mentioned that they received counselling after the diagnosis, which helped them understand what having HIV was all about. Some of them are involved in psychotherapy, which helps them accept their condition.

Planning for the future in terms of ensuring that their children are taken care of seems to contribute towards giving them a purpose in life. They reported that they are trying to save some money for their children's education when they are no longer alive. They are also arranging for other people to take care of their children in future.

6.3.2 EMOTION-FOCUSED COPING

As indicated in section 3.1.3.3, emotion-focused coping is usually used in situations that are appraised as not changeable. This type of coping serves as an emotional and arousal oriented coping style with the purpose of reducing negative emotions regarding a situation and preventing further emotional pain (Lazarus & Folkman in Moos, 1992). As Folkman and Lazarus (1985) proposed, emotion-focused strategies include behaviours such as looking on the brighter side of things, accepting sympathy and understanding from others, and trying to forget about the problem.

The women in the study used the following emotion-focused coping strategies:

a. Denial

All women reacted to the results of their tests with shock, disappointment and hurt. The prominent coping strategy employed soon thereafter was denial. Denial is defined as a defence mechanism in which the patient refuses to acknowledge some aspect of external reality that would be apparent to others (Brock, Gurekas & Deom, 1993). Denial can also be when a person totally refuses to accept the diagnosis or admits the diagnosis, denying or minimising the implications. Some participants indicated that they could not believe it was really happening to them and as a result they could not accept the news. They used denial to help shut out awareness of that which would be too disturbing, which in this case was the knowledge that their lives have changed. Mostly disturbing, was the thought that they were going to die and leave their children behind.

Since dealing with a chronic illness is accompanied by feelings of loss (Westbrook & Viney, 1982), women in this study found themselves struggling between letting go or relinquishing what has been lost and holding on to the loss so as to avoid pain experienced due to the loss. Accepting the condition meant accepting the loss, which in turn would mean the ability to deal with the pain of loss. At the time of diagnosis, these women were not ready or able to deal with their loss. Denial was therefore appropriate as it served as a cushion against trauma.

Charlotte's husband told her that he was HIV-positive. She chose to deny the truth and pretended that he was just joking because she was too afraid for both of them. During the period after the diagnosis, Lucia and Martha reported that they convinced themselves that they were just as healthy as everybody else.

b. Avoidance

Talking about being HIV-positive remains difficult for some of the women. Although they were all free to talk about their experiences with the researcher, some of them mentioned that they couldn't talk about it with other people outside their families and close friends. Keeping their status a secret somehow provides them with security against the cruelty HIV-positive individuals seem to live with on daily basis. Charlotte is keeping the truth about her status from her children and she always avoids the topic about their father's illness whenever they raise it. By avoiding to talk about both her and her husband's status with her children ensures that she doesn't have to face the reality of the situation. The fact that she sees her husband's condition as very serious to an extent that she perceives death to be inevitable, only reminds her that she is going to travel along the same route later.

After discovering their HIV status, Lucia's boyfriend at the time decided that she was not allowed to tell anyone about it, including his or her family. They also avoided talking about it among themselves. Pretending as if it didn't happen somehow made it unreal for them. Lucia also started drinking alcohol heavily to avoid thinking about her problem. Martha stated how she always felt uncomfortable at work whenever the subject of HIV/AIDS came up. She avoids talking about it since she fears that people can somehow see through her and conclude that she is infected.

Willingness and making a deliberate effort to think about the positive things in their lives help the women to avoid thinking about the disease and its negative effects. They think about good things in their lives and important people like their children and families who make them feel happy and positive about their lives. Linda added that thinking about her HIV-positive status used to give way to suicidal thoughts in the past. Since she started avoiding to think about her condition and concentrating on important people in her life and how to ensure that she lives for a longer time, she no longer has suicidal thoughts.

Fleishman and Fogel (in Moneyham *et al*. 1998) found that women with HIV used significantly more avoidance coping strategies than their male counterparts. Commerford, Gular, Orr and O'Dowd (in Vassend and Eskild 1998), who also pointed out that these types of coping strategies are significantly related to greater levels of anxiety and depression, also reported similar findings.

c. Religious Faith

All the women indicated that they place God or the higher power in control of their lives. They stated that they see their faith as a source of help in coping with their HIV status. Their belief makes it easier for them to think about death and dying because they put their lives in God's hands. This makes them believe that when they die, it will not be because of HIV or AIDS, but it will be the time God has decided upon for them to die. The belief also helps them perceive their lives as being the same as everyone else's, in a sense that everyone is going to die when their time comes. Kain (in Groomes, 1998) noted that when people infected with HIV are given a chance to pursue spiritual matters, psychological growth often occurs.

Linda mentioned that she listens to gospel music and always sings along. This helps her feel strengthened and good inside. Prayer forms an important part of their daily activities. Martha believes that God has a purpose for every one of us and life is just as God wants it to be. The fact that she also perceives God as being punishing gives her satisfaction when she thinks that the person who infected her will answer to God one day.

d. Acceptance

With acceptance, a person admits the diagnosis and accepts the implications. He/she realistically admits to fears and seeks ways to confront and deal with emotions (Brock *et al*., 1993). The period it took for the women in the study to come to terms with the presence of the virus in their bodies varies.

The decision to accept the condition meant no longer denying the virus' existence in the women's bodies. All the women had reached a stage where they are able to face up to their fate and accept what happened to them. Linda stated that she has to accept herself first with everything that is happening to her before she expects other people to accept her. To those women who have decided to be open about their situations, talking or telling people about it required self-acceptance first in order for them to be genuine. Accepting the situation generally changed their lives for better, but it also meant that they had to accept the inevitability of death since there is still no cure for AIDS.

e. Social Support

The strategies that a person uses to help him/her deal with difficult circumstances are closely related to the resources available to that person. These resources include financial, social and emotional resources (Antonovsky, 1979). It has already been mentioned that the GRRs can be interpreted in terms of social support as discussed in section 3.1.6. The resources available to the women (GRRs) will be incorporated in the discussion that follows.

All the women in the study received some form of social support from either their spouses, families, friends, or other members of the public. They all pointed out that the support they received assisted them in coping with the difficulties of living with HIV.

Emotional support or emotional GRR is considered important since it gave the women an opportunity to be open and honest about their condition and the associated feelings. This is supposed to be the case especially with people who are perceived to be non-judgemental like family members. Listening, showing concern, warmth, love and understanding provides an opportunity for self-disclosure, which is a process through which one lets oneself be known, either verbally or non-verbally, by another person (Kimble, 1990).

Cohen and Wills (1985) and Manuel *et al.* (1987) describe how perceived support is more important than the support that is actually available. One participant did not receive emotional support from her family, although she expected to get it. The result was fear of disclosing her status to any other person thereafter. Believing that they will be accepted in spite of revealing their imperfections could have enhanced their feelings of self-worth. The confidence that is associated with feelings of self-worth positively influenced the way in which the women managed the challenges associated with being HIV-positive.

Emotional support also includes being in the company of people whom one can relax with and be comfortable. Sharing of personal information and experiences takes place within this context, which is the reason the women felt that they need to belong to a support group. The exchange of personal information in this case can be rewarding for both parties (Kimble, 1990). Support groups also assist group members in arranging their everyday lives outside the group setting so that they receive naturally occurring social emotional, and coping support (Kelly, 1998). Those women who reported to have attended the support groups stated their importance in terms of providing the platform for unloading emotionally.

Provision of counselling and psychotherapy serves as another emotional GRR to HIV-positive women. Some of the women in the study got an opportunity to be involved in therapeutic relationships which are seen as non-judgemental, giving them an opportunity to disclose personal information. The advantages of this disclosure include that it is considered therapeutic when the therapist who is listening accepts the disclosure (Rogers in Kimble, 1990) and that it contributes to self-clarification (Rosenfeld & Kendrick in Fehr, 1996). Prager (1995) noted that lack of disclosure of personal information has been associated with illness and distress.

Informational support and cognitive GRR like provision of knowledge through things like counselling and workshops were viewed by women in this study as important. As described earlier in section 3.1.6, this type of support includes provision of information and advice, which could assist a person in solving problems or giving feedback on how a person is managing his/her life. Sheridan and Radmacher (1992) consider knowledge to be a very important resource. All women in this study viewed exchange of ideas and advice and provision of alternative perspectives as helpful in helping them cope. Sharing information and advice assisted them in solving problems more effectively. An example of this would be sharing information about where to go in case one needs treatment urgently, how to go about disclosing one's status, and how to keep healthy. All this information and advice may contribute to women viewing their problems differently and therefore getting an opportunity to look at their options. This process may lead to a woman to reassess her situation in a more positive way.

Social companionship or just being in the company of other people is seen as another GRR, which is usually provided by friends (Fehr, 1996). This type of support provides company by spending time with others in leisure and recreational activities. Lucia mentioned how she enjoys just sitting and talking to her friends, whereas Charlotte described the time she spent with her colleagues at work making jokes and laughing. This helps facilitate a positive mood, which in turn helps distract a person from worrying about problems.

6.3.3 THE RELATIONSHIP BETWEEN THE SENSE OF COHERENCE AND COPING

The strength of the women's sense of coherence (SOC) is not precisely known since the purpose of this study was not to measure it. Despite this, the components of SOC namely meaningfulness, comprehensibility and manageability can still be generally related to the results of the study. This relationship will be discussed here.

Antonovsky (1979) describes SOC as general and long-term ways in which the person views his/her life, and not only the personal experiences in relation to the current context. According to Antonovsky (1979), an event is interpreted and experienced within the context of the person's SOC.

Health can be promoted when there is motivational and cognitive bases for transforming one's potential resources appropriate to a given stressor (Antonovsky & Sourani, 1988). This implies that a person can be able to deal with a particular stressful situation if he/she is willing and capable of thinking about how to adequately utilise the resources at his/her disposal. In relation to this study, the implication is that those women with a strong SOC will have the ability to utilise GRRs at their disposal.

Antonovsky (1987) refers to manageability as the feeling that one has adequate resources to meet one's demands. A sense of manageability protects an individual from feeling like a victim or feeling as if life is treating him/her unfairly whenever he/she is going through difficult times (Antonovsky, 1990). Manageability also implies being able to trust oneself and others, with a belief that things will work out as well as can be expected. Women in this study have spouses, friends, or family members who are very supportive. Some even have colleagues they can talk to about their problems. They also have access to medical support in a form of treatment, counselling and psychotherapy. Because of the resources they have to help manage their lives, women in this study realised that unfortunate events do occur in life but such experiences can be survived and coped with.

The ability to make sense of the world and judge reality is referred to as comprehensibility (Antonovsky, 1987). Even though some events may not be desirable, people who have the characteristic of comprehensibility expect that they can make sense of them. In the beginning, just after the diagnosis, the women in this study couldn't make sense of what was happening to them and they perceived themselves as losers. Accepting themselves and being accepted by others with their condition helped them have hope that things will work out as reasonable as can be expected. They are also making sense of what is happening to them by thinking of it as God's intention and will.

The motivational element of the SOC, meaningfulness, refers to the sense that life's demands are challenges worthy of investing energy in, rather than burdens (Antonovsky, 1987). The informational GRRs such as giving advice and exchanging personal information proved to play a significant role in the lives of women who are HIV positive since they helped them reappraise their situation, and thereby finding alternative ways of coping. Reappraisal can assist in changing one's perception of events from being seen as threatening, to seeing them as challenges. In this study, HIV-positive women ended up seeing their conditions as challenges worthy of engagement and they decided to take up to the challenge by living their lives to the full. They take each day as it comes and handle daily hassles as they arise. The women in the study also mentioned that they are involved in educating others about HIV and AIDS. They mentioned that it helps them feel that they are contributing towards the fight against the disease. This can also be seen as finding meaning for their lives.

As Antonovsky (1987) pointed out, the SOC is stable on the whole around the age of thirty years. The person's orientation to life, her experiences and her life contexts, however, change. These experiences and contexts interact with and potentially enhance the components of SOC. It has already been stated that although the components can be distinguished, successful coping does not depend on a specific component, but on SOC as a whole.

6.4 CONCLUSION

This chapter provided the discussion of results on experiences of women diagnosed with HIV, and how these women cope with their condition. In the discussion, the results were integrated with the literature and the theoretical approach applied. The following chapter will provide some conclusions drawn from the study.

ERRATA

Change the word "loose" to "lose" on the following pages
p. 10, line 22
p. 69, line 9
p. 71, line 28
p. 72, line 11
p. 74, line 12
p. 80, line 14 & 15

Change the word "loosing" to "losing" on
p. 17, line 11
p. 72, line 5, 6, 8
p. 80, line 10
p. 82, line 11

p. 11, line 19: "women are" should be "women were"
p. 12, line 21: "legions" should read "lesions"
p. 17, line 25: "reported against" should be "reported by"
p. 17, line 26: "occur" should be "occurs"
p. 25, line 27: "undimensional" should be "unidimensional"
p. 35, line 9: the word "her" should be inserted before "children"
p. 41, line 13: "a individual" should read "an individual"
p. 46, line 6: "a" should be inserted before "friend's"
p. 53, line 10: "hem" should be spelt "them"
p. 63, line 10: the word "a" should be inserted before "few"
p. 71, line 21: "concern and" should read "concern with, and"
p. 85, line 21: "live the way" should be living the way"
p.92, line 6/7: "Hate feelings" should be "Feelings of hate"
p. 96, line 25: "other people" should be "some people"
p. 101, line 7: "a" should be inserted before "daily"
p. 103, line 8: the word "the" should be inserted before "better"
p. 103, line 29: "by another should read "to another"