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A MODEL OF COGNITIVE BEHAVIOURAL THERAPY FOR HIV-POSITIVE WOMEN TO ASSIST THEM IN DEALING WITH STIGMA

by

JAN TSHABALALA

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SUPERVISOR: PROF. M.J. VISSER

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DEDICATION

This dissertation is dedicated to

HIV-positive people, from whom we learn so much on a daily basis.

ABSTRACT

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

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

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

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

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

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

KEY TERMS

Women living with HIV

Cognitive behavioural therapy (CBT)

HIV/AIDS-related stigma and discrimination

Psychometric scales

Coping with HIV/AIDS

Stigma

CBT model dealing with stigma

Mixed methods research

Case studies

Quasi-experimental design

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