

## CHAPTER 3

### THEORETICAL PERSPECTIVES ON HOW TO FACILITATE CHANGE THROUGH PSYCHOTHERAPY

#### 3.1 INTRODUCTION

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

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

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

#### 3.2 COGNITIVE THERAPY

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

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

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

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

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

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

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

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

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

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

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

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

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

### 3.2.1 Important Cognitive Factors

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

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

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

### 3.2.2 Cognitive Techniques

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### 3.2.3 The Use and Limitations of Cognitive Therapy

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

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

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

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

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

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

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

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



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

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

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

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

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

### 3.3 BEHAVIOUR THERAPY

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

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

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

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

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

#### 3.3.1 General Principles

Behaviour therapies are based on a few assumptions:

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

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

### 3.3.2 Behavioural Techniques

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### 3.3.3 Evaluating Behaviour Therapies

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

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

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

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

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

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

### **3.4 COGNITIVE BEHAVIOUR THERAPY (CBT)**

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

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

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

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

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

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

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

CBT is built on three fundamental propositions, namely:

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

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

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

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



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

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

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

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

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

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

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

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

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

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

#### **3.4.1 The Use and Limitations of Cognitive Behaviour Therapy**

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

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

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

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

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

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

### **3.5 A GUIDELINE OF THE INTERVENTION MODEL**

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

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

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

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

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

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

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

## CHAPTER 4

### RESEARCH METHODS

#### 4.1 INTRODUCTION

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

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

#### 4.2 QUALITATIVE AND QUANTITATIVE METHODS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **4.3 RESEARCH DESIGN**

The current research was conducted in two phases.

### **4.3.1 Phases of the Research**

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

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

#### **Phase 1: Development of an Intervention Model**

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

- Study of the available literature

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

- Researcher's own experience

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

- Focus group discussions with colleagues

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



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

- Interviews with HIV-positive women

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

- Psychometric scales used on HIV-positive women

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

#### **4.3.2 Focus Group Discussions with Colleagues**

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

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

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

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

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

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

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

### **4.3.3 Interviews with HIV-positive Women**

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

#### 4.3.3.1 Sampling

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

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

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

#### 4.3.3.2 Data collection methods

- **Interviews**

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

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

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

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

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

- **Psychometric instruments**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### **4.3.4 Ethical Considerations**

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

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

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

#### **4.3.5 Data Analysis**

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

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

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



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

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

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

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

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

## **Phase 2: Implementation and Evaluation of an Intervention Model**

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

### **4.3.6 An Intervention Model**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- The experience of the reaction of others

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### **4.3.7 Evaluation of the Intervention Model**

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

##### **4.3.7.1 Participants**

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

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

##### **4.3.7.2 Design**

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

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

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

#### 4.3.7.3 Data-gathering instruments

Two ways of gathering data were used:

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



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

### 3.3 Manoeuvres and behavioural patterns

#### 4 The participant's system

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

#### 5 Hypothesis

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

#### 6 Symptoms

#### 7 Goals of therapy

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

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

### 4.3.7.4 Data analysis

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

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

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

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

#### **4.3.7.5 Ethical considerations**

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

### **4.4 ACCURACY AND RELIABILITY OF DATA**

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

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

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

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

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

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

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

#### **4.5 THE RESEARCHER'S ROLE**

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

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

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

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

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

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

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