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*Original Article*

# Relationship Between Psychotherapy and Mitigation of Self-Stigmitization Among Adult Persons Living with HIV in Nairobi City, Kenya

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## ABSTRACT

Human Immunodeficiency virus (HIV) has caused a lot of suffering ever since the first case was reported. To date there are about 80,000,000 People living with HIV (PLWH). Although the rate of new infections has reduced, the effects remain far reaching, especially in Sub-Sahara Africa. Apprehension associated with HIV often scares many from finding out their HIV standing, considering restraint methods, avoiding risky conducts, and uplifting of PLWH endeavours. Many studies focused on HIV testing and counselling services which is for now mainly service provider driven. The drive of this study was showing the relationship between psychotherapy and mitigation of self-stigmatization (SS) among Adult PLWH in Embakasi East Sub-County (herein denoted Embakasi East), Nairobi City, County (herein denoted Nairobi City), Kenya; Social Cognitive Theory guided this study, employing descriptive research design on a target population of 3,886 PLWH registered for ART treatment at 7 public health centres in Embakasi East, Nairobi City. Cochran's sample size formula was applied in determining the suitable sample size of 246 that was confirmed by the sampling table. Purposive sampling was used to select both the public health centres and the informants from each centre. Proportionate random sampling assisted in picking participants (both male and female), then random sampling was used to construct the sample. The sample of 246 (74 males and 172 females) was drawn, with 6 informants. Informants were interviewed and questionnaires completed by PLWH. In the analysis of the data, descriptive statistics, mainly frequencies, percentages and mean were applied on facts while thematic analysis on qualitative data. The study results showed that SS was very prevalent, caused by the respondents themselves and those around them. They acknowledged being hated, them hating themselves and did not want their HIV status known. Just a few had utilized psychotherapy service, who agreed that they were relieved a lot of pain they were undergoing, and they recommended it to others. The study recommended that authorities need to consider promoting and committing resources for psychotherapy as a solution to SS among PLWH, invest more in advocacy work, and invigorating sensitization among families on their role in supporting PLWH being.

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## INTRODUCTION

According to UNAIDS (2021) statistics reveal that people infected with Human Immuno deficiency (HIV) were over 79.3 million. The report also shows that death attributed to HIV/AIDS-related diseases stood at least 36.3 million people. Most of the affected people reside in the developing nations with Sub-Saharan Africa carrying the greatest burden, where over 310,000 people have died. Kenya has been affected by this pandemic harboring about 1.6 million PLWH. Having an adult HIV prevalence rate of 4.5% (UNAIDS Data, 2020), it signifies a great improvement compared to earlier years. Many have described the HIV epidemic as an epidemic of ignorance, fear and denial leading to stigmatization of the PLWH and their family members (Sidibe & Goosby, 2013).

Labra and Thomas (2017) in their work referred to HIV-related stigma as "a mark of shame which invokes unfairness, discrimination, discounting, discrediting, and harmful attitudes, beliefs and behaviours targeted at individuals with or perceived to have HIV infection, their people and societies with which they are connected to" (P43). This stigma has been established to depressingly affect value of life among PLWH (Yator *et al*., 2021).

According to Turan *et al*. (2017), PLWH suffer enacted stigma, where they are labelled, rejected, or victimized due to their HIV status. These responses hinder PLWH from looking for medical attention and could result in bad consequences on well-being after-effects on viral load and CD4 counts. Anticipated stigma affects PLWH when they suspect they would be subjected to demeaning convictions due to their HIV status. This stigma can badly affect medication observance when PLWH aggressively evade testing services, and medical help. Internalized stigma on the other hand, subjects PLWH to feelings of bad self-image, shame, and guilt due to their HIV status.

Once PLWH experience prejudice regularly, they report greater levels of internalized stigma which response is deeper in those affected, who feel elevated degrees of stigma (Turan *et al*., 2016). But it has been confirmed that PLWH that feel intense stigma are more likely to suffer internalized stigma (Turan., Fazeli *et al*.,2017). Those with high extreme internalized stigma in turn, were observed to experience stigmatizing attitudes from others. This study focused on internalized self-stigma that happens when one has consciousness of a stereotype or negative perception, subscribes to them, and finally, apply them onto oneself (Gunasekaran *et al*., 2022). HIV stigmatization has been associated with several factors. First, many jurisdictions have passed laws with a view of minimizing spread of HIV which caused PLWH a lot of sufferings (Harsono *et al.*, 2016). These laws establish restrictions such as the obligatory screening and testing of people, barring PLWH from engaging in specific professions and certain jobs, health checks required in different circumstance, seclusion, confinement, embargos on

 

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international travel, just but to mention a few. Second, failure of the family to play its critical role. Evidence exists confirming the significant part that family can perform in affording support and care for PLWH (Öktem, 2015).

On the contrary, families snub seropositive members because of being linked to HIV and the undertones of same sex activities, narcotics abuse and immorality that are linked to being HIV positive (Xu *et al*., 2017). Third, screening required before one is employed exerts pressure on PLWH. In some countries this screening has been used to dehumanize PLWH especially where it is part of conditions for entitlement to health benefits available to employees (Dipeolu, 2015). Due to unfair treatment by employers, co-workers, clients and customers at workplace, PLWH find it difficult finding or maintaining a job and thus tend to engage themselves more in the informal economy. The great sufferings associated with HIV prompted the international community come up with various counter interventions. The International Federation heavily financed health care with strong commitment to ramping-up prevention, destigmatization, activism, delivering health care and other services related to HIV to susceptible people. Under "Global Partnership for Action", abolishing HIV-related stigma and discrimination stands essential in achieving Sustainable Development Goals (SDGs) targets, including ending AIDS, by 2030.

Global AIDS Strategy (2021-2026) advocates for obligations worldwide to discourse on HIV-related stigma and discrimination. This strategy identifies precise measurable targets to be implemented on group enablers touching on convenience to justice and eliminating punitive laws, stigma, and violence. It targets less than 10 per cent of PLWH and key populations experiencing stigma and discrimination if successful. Noticeably, many years since the first HIV cases were reported, HIV-related stigmatization continues to impact many despite these many interventions being undertaken.

In Kenya, to protect the rights of PLWH, HIV and AIDS Prevention and Control Act (HAPCA) came about in 2006 that established a tribunal mandated to resolve complaints of violations of provisions in HAPCA. Further, Kenya has a national plan (Kenya AIDS Strategic Framework 2020/21-2024/25) that spelled out its response to HIV and the related stigmatization at both national and county levels.

Other initiatives have contributed positively to the fight. Baugher *et al*. (2017) in their study found out that groups such as bisexual persons supposedly with high risk of stigma could benefit from highly customized interventions. They also noted that initiatives emphasizing skills-building in young adults just tested HIV positive could be effective in reducing internalized stigma. This would be possible if there was proper management of negative feelings towards oneself or other PLWH, increased talk about HIV to others and imparting knowledge on combating the menace. It has also been established that society groups related initiatives such as anti-stigma media campaign have worked well in reducing stigma toward PLWH in the general population (CDC, 2016).

Casale *et al*. (2019) work within Zimbabwe unveiled that adolescent living with HIV frequently suffered internalized stigma. Internalized stigma causes low uptake of available HIV treatment, resulting in increased infections and death. Given the psychological and emotional strains HIV imposes on PLWH and those closest to them, it is possible that psychotherapy could have a relationship with HIV-related stigmatization.

Goldfried (2013) defined psychotherapy as the means of treating psychological illnesses and distress through the use of verbal and emotional techniques. Psychotherapists walk through clients by developing therapeutic relationships with them. The client is assisted in tackling their problems which would be related to mental illness or a source of life stress, in scheduled therapy sessions. According to Krause *et al*. (2015), therapeutic change is expected as clients work on

 

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their problems, gain understanding, achieve personal satisfaction, and become self-dependent. This process transforms their problems and symptoms, self-awareness, and interaction in the environment they find themselves.

Ma et al. (2019) stated that internalized stigma possibly would head into poor mind well-being conclusions, including nervousness, strain, dejection, reduced self-worth, reduced self-appreciation, desperation, and even harbouring suicidal feelings. They carried out analysis of literature and came across 23 studies on of HIV related self-stigma. Psychotherapy was one of them but not as popular as psycho-educational interventions. They attributed this outcome to limited research associated to psychotherapy. Akatukwasa *et al*. (2021) working on dimensions of HIV-related stigma in rural communities in Kenya and Uganda authenticated the affected consenting to social attitudes, fears, and discrimination among the PLWH involved. They had strong backing feedback of emotions of insignificance, disgrace, and humiliation.

**Statement of the Problem**

HIV-related stigma and discrimination are topical issues within behavioral research around promoting transparency to address social downgrading of those affected with their families (Berendes & Rimal, 2012). Under the UN initiative of *the* "*Getting to Zero*" in 2011, developing countries especially in African pledged to reducing fresh infections, stigma, intolerance, and fatalities caused by HIV to nil come 2030. It is however difficult to surmount HIV-related stigma and discrimination merely by top-down programs and messaging crusades (Parkhurst, 2014). According to National Aids Control Council (NACC) Kenya County profile report (2016), Nairobi City where Embakasi East is located benefitted from most national programmes and facilities initiated to counter the effects of HIV in Kenya.

Despite the heavy investment in ant stigma, documented evidence from facilities working with PLWH indicate that stigma among PLWH remains high, especially internalized stigma. Baseline Stigma and discrimination Index (SDI) in 2014 by NACC placed Kenya and Nairobi City at an overall score of 45 and 40 respectively. This needs to reduce further if the desired impact on HIV infection's reduction is to be achieved. There is evidence that HIV-related self-stigma is significantly linked with severe depression and reduced self-efficacy (Logie., Tharao, 2013). Earlier work proposes that integrated mental health programs would return a better result in countering the effects of HIV-related stigma (Yator *et al*., 2021). Despite the many studies, the main topic of concentration has been "HIV testing and counselling" which in Kenya remains service provider driven. Usefulness of psychotherapy which is client centred needs to be considered as it could have good results. Psychotherapy being a mental health treatment could play a critical role. There is therefore a need for empirical study findings on the relationship between psychotherapy and mitigation of SS among adult PLWH.

**Objectives of Study**

- To Establish whether Psychotherapy Services were used by Adult PLWH in Mitigating SS.

**Research Questions**

- Did adult PLWH in Embakasi East, Nairobi City use Psychotherapy Services to Mitigate SS?

**LITERATURE REVIEW**

**Use Psychotherapy Services to Mitigate Self-Stigmatization**

The work of Mojaverian et al. (2013) confirmed that psychotherapy can offer help to manage questions that PLWH face, supporting them survive on their own. Marsh and Wilcoxon (2015) stated that psychotherapy could be useful to individuals who understand their challenges in life and are ready to pursue help.

Thorpe (2013) conceded that professional counselors through psychotherapy could give the much-needed help to boost the psychologic feeling of the affected person. This seems good news to PLWH who encounter a range of

 

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stigmatizing incidences like degrading behaviours, gossip, verbal abuse, and social rejection (UNAIDS, 2020 Report). Yator *et al. (*2022) in their work on acceptability and impact of group interpersonal therapy (IPT-G) on Kenyan adolescent mothers living with HIV noted that emotional interventions are advised for PLWH to alleviate normal psychological illnesses, including depressive illnesses. Their work established acknowledgement from participants that IPT-G aided in managing depressive signs of social seclusion, rage, despair and low feelings.

These sentiments buttress the findings by Akatukwasa *et al*. (2021) reiterating the critical function of shared, gender-focused rules and control constructs in building domestic standards around HIV-related stigma. There is need to emphasize the importance of agreeing on widely shared and basic causes when designing and executing stigma alleviating strategies (Pantelic et al. 2019). An effective approach would be based on a multi-level approach that concedes to differences in individuals' stigma experiences considering the multiple stigmatized characters and the collaboration between them (Turan *et al.*, 2019).

Psychotherapy can help stabilize the mental problems if taken in good time. Krause *et al*. (2015) in their study on generic change indicators in therapeutic processes with different outcomes, attempted to establish the relationship between ongoing change and final outcome in therapies performed among 39 clients in native localities. These clients respected short-term therapies fitted diverse theoretical orientations, comprising a range of modalities (individual, family, couple, and group therapies) and occurred in numerous mental health services in Santiago de Chile in 2009.

In the current study, the test was simplified to experiences of those PLWH who were suffering from self-stigmatization (SS) and opted to seek psychotherapy services. They expressed themselves on whether they felt some relieve or not which much easier to understand from the practical level. However, past studies mentioned above failed to appreciate the important considerations and options authorities must adopt in increasing the uptake and usefulness of psychotherapy by PLWH such as availability and affordability of such service to them and how well to manage the myths that come with it.

**Theoretical Framework**

This work was guided by Social Cognitive Theory (SCT) which underscores significance of witnessing, and mimicking the behaviors, manners, and demonstrative responses of others (Luszczynska *et al*. 2020). SCT is based on six principles: reciprocal determinism, behavioral capability, observational learning, reinforcements, expectations, and self-efficacy. Reciprocal determinism involves vibrant and mutual contact of PLWH, surrounding, and conduct. Behavioral capability is a PLWH's power using necessary understanding and abilities in performing a certain mannerism. Through observational learning, PLWH sees and discerns a behavior others exhibit, and imitates them.

Reinforcements entail both inner or outer responses on how a PLWH's reacts that prompt his or her chances of carrying-on otherwise cancelling the action. Expectations would be the predicted PLWH feedback. PLWH would suspect results of their actions prior to display which in turn impacts the achievement of the behavior to completion. Self-efficacy is something in the PLWH that gives conviction to the PLWH's knack to enact a reaction. This depends on one's 'abilities as well as factors in the surroundings. SCT has easily been applied in well-being promotions given its reliance on the individual and the environment where they find themselves (Turan *et al*., 2019).

When a PLWH with mental problems undergoes psychotherapy sessions, he or she will share experience with the therapist in conducive environment, who will help the PLWH within prearranged sessions. The therapist will give various perspectives of issues and allow the PLWH to find suitable answers. Outcome expectation represents the PLWH beliefs that indeed they can be well. Self-efficacy comes in

 

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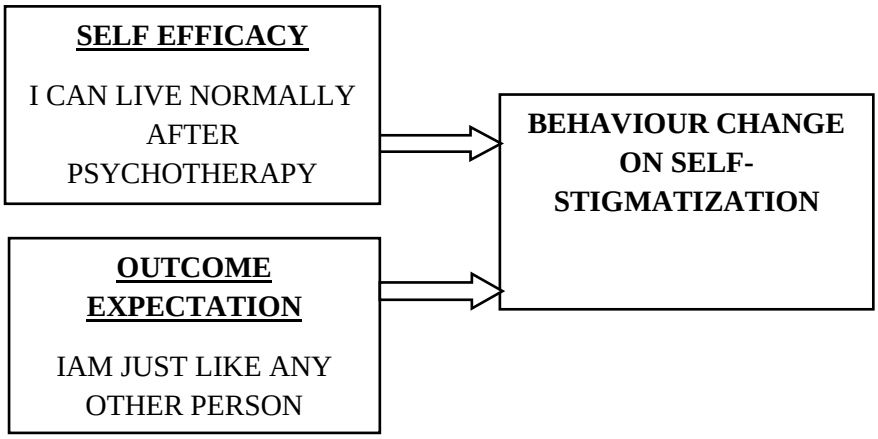
when PLWH's believe they can benefit from the process, learn new coping strategies to lead a normal life. Change in PLWH state of mind is affected by positive and negative effects of material losses and benefits. However, SCT considers stigma as something in the affected PLWH and not a trait that another person could pass over to the PLWH (Sidibe., Goosby, 2013).

It portrays stigma as a stagnant trait and not a changing shared phenomenon. This weakness was managed by critically considering the structural situations of the PLWH and recognizing that, stigma is experienced at the point labelling, stereotyping, separation, and discrimination strike simultaneously with exercise of authority. The resulting abstract posits that good interventions should have both socio cognitive and structural components. It acknowledges that social, political, and economic inequalities of power stimulate HIV-related stigma and discrimination. At foundational form, SCT delves into a person's past experiences, which is a determinant of whether the affected PLWH change their behavior. These past experiences, control reinforcements, expectations, and expectancies are critical and that in turn could inform whether the PLWH will engage in a specific behavior and the reasons for this reaction.

**Figure 1: Social Cognitive Theory**




**Conceptual Framework**

The study was guided by the conceptual framework as laid down in Figure 2. Disparities that exist in various aspects of power give the base on which stigmatization thrives. Underlying aggression and preceding stigmas incentivize control of stigmatisers, resulting more intense stigmatization when internalized. Stigma develops when labelling, stereotyping, separation/status loss, and discrimination in the setting of power difference concurrently congregate. Those with power employ ''stigmatized'' values, identities, and discourse through interactions between PLWH and the non-stigmatized person. Such fuel SS in the PLWH. Undermining these dominating behaviours can happen when there is fair distribution of resources between the stigmatized and the non-stigmatized, and at the same time, for the stigmatized to strive toward a competitive position against stigmatizers in which case psychotherapy could help. Through psychotherapy, those affected can understand what is best for them and lead a more positive life. However, several intervening factors may come to play. Access to healthcare minimizes the suffering of PLWH from the health effects of HIV as well as the stigma associated with the scourge. Community support and involvement of PLWH in programmes that promote them have worked well in minimizing HIV-related stigma. Use of ARVs helps PLWH to lead normal live by reducing the viral loads in their bodies. Spirituality/religion helps PLWH cope with negative thoughts and handling of stressful situations while maintaining their calm.

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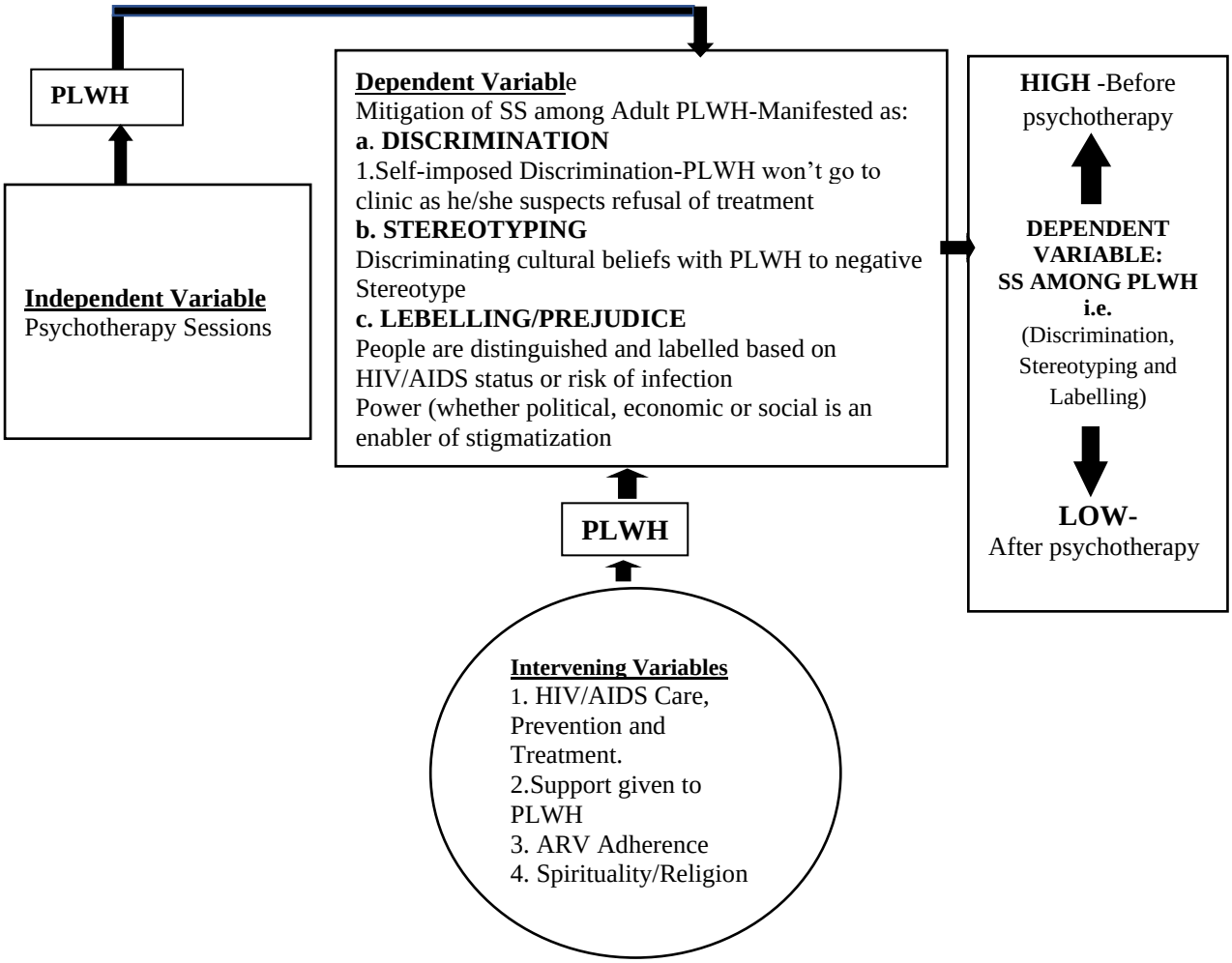
**Figure 2: Conceptual Framework on Relationship Between Psychotherapy and Mitigation of SS Among Adult PLWH**




## RESEARCH METHODOLOGY

### Research Design

The work adopted a descriptive research design which depicted population, position or happening and sought to reply to questions; what, where and when. Descriptive data is often gathered using Observations and survey methods (Sahin, 2021). The key objectives of research are to describe, explain, and validate findings. Description comes out well after an investigation is undertaken and the facts collected analysed, presented and conclusion made. This research design fits into both quantitative and qualitative approaches. Descriptive research is cross- sectional where different parts of a set are studied. It allows gathering measurable facts that are scrutinized from the selected part of the reference population. Descriptive research design enables easy collection of relevant and appropriate data, it allows designing premises in a study and facts for possible future works, and perhaps crucial, data is collected in the place where it occurs, without any type of alteration that reassure its value and integrity remaining intact. However, where foundation questions are not well framed, facts obtained could fail to give credible findings. Further, the types of variables used in descriptive investigations may make it difficult picturing the causes and effects of the event.

### Target Population of the Study

Njeru (2015) described a target population as a universal set of study of all members of a real or hypothetical set of people, events, or objects to which an investigator wishes to generalize the result. Nairobi City has many PLWH dealing with various and different thematic issues. This study

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was conducted in Embakasi East that had an estimated 7,261 PLWH on ARVs of which 9% were less than 18 years old (NACC, 2019). Adult population of 6,587 had about 60% being served in public health centres as summarized in table 1 below:

**Table 1: Distribution of Target Population in the Public Health Centres in Embakasi East**

| Type of Health Facility | Name | Male | Female | PLWH on Treatment |
|---|---|---|---|---|
| **Public Health Centres** | APTC | 82 | 192 | 274 |
| | Embakasi | 237 | 554 | 791 |
| | Garrison | 58 | 135 | 193 |
| | Mukuru | 300 | 700 | 1,000 |
| | GSU Training Sch. | 76 | 178 | 254 |
| | Kayole II | 217 | 507 | 724 |
| | Kayole I | 195 | 455 | 650 |
| | **Total** | **1,165** | **2,721** | **3,886** |
| **Private Health Centres** | Private centres | 1,683 | 1,018 | 2,701 |
| **Total** | **TOTAL** | **2,848** | **3,739** | **6,587** |

**Sampling Techniques and Sample Size**

Njeru (2015) defined sampling as the technique applied marshalling people, places, or things to an enquiry. The study was undertaken at public health centres where HIV service provision is free. The study applied non-random sampling (purposive sampling) at different levels. First, in selection of Nairobi City as the location of the study, because of its substantial contribution to new cases of HIV infections, well established health infrastructure, the existing numerous HIV prevention and management initiatives, and the well-coordinated HIV-related stigmatization campaigns. Secondly, in selection of public health centres where participants were drawn from, since only 7 public health centres existed in Embakasi East at the time of the study. Third, the selection of the adherence officers/community health volunteers that was guided by their acceptance to participate in the study. Further, proportionate sampling was applied at two levels, in ensuring that the selected sample represented the various relevant components of the population. First, when apportioning samples that were drawn from each public health centres as compared to the study population, N, of 3,886 (Table 3.1), and then apportioning the number of both male and female participants from each public centre. Finally, the study relied on random sampling in the construction of the sample to ensure each PLWH was given an equally opportunity to be part of the sample.

The sample size was determined by standard table from a given population according to Njeru (2015)**.** A sample of 246 is assigned to populations greater than 3,500. In confirming the sample size, Cochran's sample size formula was applied where sample size (n) is calculated as follows: $n_0 = Z^2pq/e^2$ where: $n_0$ is the sample size, Z is the number of standard deviations from Z table, p is the estimated proportion of the population with stigma, q is 1-p and e is the desired level of precision (the margin of error). Supposing Z = 1.96, p= 80%, q=20%, e=0.05, $n_0 = 1.96^2(0.65)(0.35)/(0.05)^2 = 246$.

**Table 2: Distribution of Sample Size in the Seven Public Centres**

| | Name Public Centre | Population | Sample size | Female sampled | Male sampled |
|---|---|---|---|---|---|
| **1** | APTC | 274 | **17** | 12 | 5 |
| 2 | Embakasi | 791 | **50** | 35 | 15 |
| 3 | Garrison | 193 | **13** | 9 | 4 |
| 4 | Mukuru | 1,000 | **63** | 44 | 19 |
| 5 | GSU Training Sch. | 254 | **16** | 11 | 5 |
| 6 | Kayole II | 724 | **46** | 32 | 14 |
| 7 | Kayole I | 650 | **41** | 29 | 12 |
| | **Total** | **3,886** | **246** | **172** | **74** |

 

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**Research Instruments**

Interview schedule was used to collate the relevant facts from for informants while questionnaires were applied to participants selected in the sample (Njeru, 2015). During the study, interviews were administered to the informants who served PLWH at the public health centres. The study sought to understand the pool of PLWH at each centre, if there existed a list how this information would assist in getting a representative sample. There was also consensus on how the selected PLWH would be reached especially during the comprehensive care clinics visits. The informants provided the initial information on whether the PLWH exhibited signs of SS and created the necessary rapport. The interview guide used in the study.

Further, the questionnaire was designed such that it clearly stated the objectives of the study and who was conducting it. It had in total about 38 questions covering demographic information, respondents' comments on prevalence of HIV-related SS, respondents' thought patterns, respondents' emotional reactions, respondents' behaviour when experiencing HIV-related SS and respondents' experience on how psychotherapy helped if at all they utilized it when suffering SS.

**Data Analysis**

Facts compiled were coded and manipulated through statistical tools such as statistical package for social sciences (SPSS) version 23. Qualitative data was analysed thematically. Information was initially clustered based on the identified objectives in each focus area. Analysis was done, and the results presented. Pearson Product Movement was used to determine existence of linear correlation between, psychotherapy and SS.

**RESEARCH FINDINGS AND DISCUSSIONS**

Research findings and discussions are deliberated in this section on whether psychotherapy services were used by adult PLWH in mitigating SS.

**a) Linking Psychotherapy to Self-Stigmatization Among Respondents**

This section established whether psychotherapy was used by Adult PLWH in mitigating SS.

***Need for Psychotherapy Services.***

The respondents were asked to comment on whether they needed psychotherapy to manage their condition. Figure 3 summarizes the responses as given below.

**Figure 3: Need for Psychotherapy Services Among Respondents**


Figure 3 shows slightly less than half of the respondents agreed that they needed professional help (psychotherapy). However, the majority indicated that they did not require professional help. This could suggest that most of the respondents either did not understand counselling service, the services were not available or were out of reach. One of the respondents commented that:

> *"I do not understand how counselling would help me. It is only helpful to the rich who can afford it. I only need psycho support as I manage my situation [PHC/A1/18]".*

 

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***Utilization of Psychotherapy***

It was critical confirming whether psychotherapy services were utilized at any time to help mitigate SS situation. Table 3 below summarizes responses obtained:

**Table 3: Utilization of Psychotherapy**

| Seen a Professional | f | % |
|---|---|---|
| Yes | 68 | 28.0 |
| No | 178 | 72.0 |
| **Total** | **246** | **100.0** |

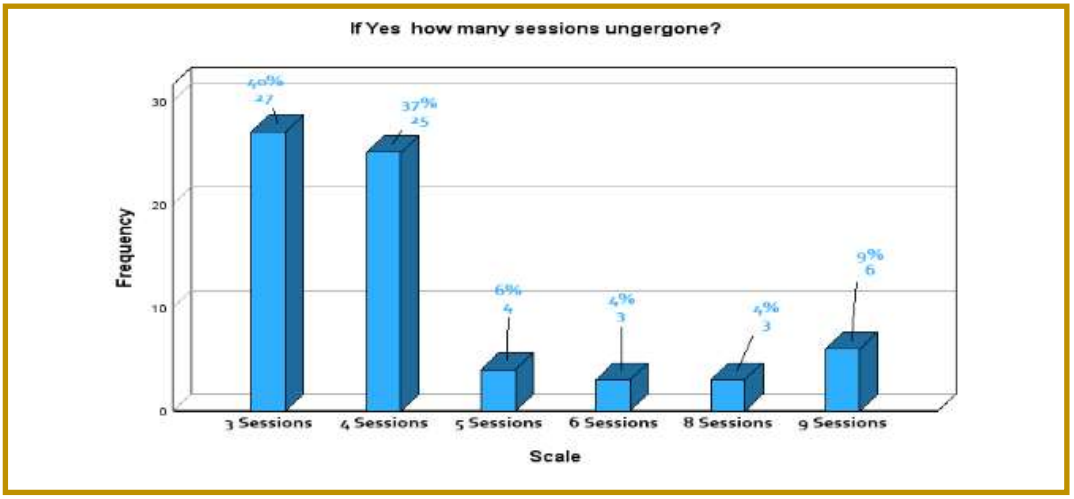
Table 3 depicts less than a third indicated to having utilized psychotherapy from a professional while the majority did not. This again points to lack of understanding on the part of respondents on the role of counselling.

> *"I am not educated to understand this service. I suspect someone cleverly wants to get personal information of my status. I would prefer accessing ARV medicines or financial assistance [PHC/M1/4]".*

***Number of Sessions Attended***

For the respondents who sought psychotherapy, they were asked to indicate how many sessions they attended to be capable of managing their experiences. This feedback is summarized in Figure 4 below:

**Figure 4: Number of Psychotherapy Sessions attended by respondents**




From Figure 6, most respondents attended either 3 sessions or 4 sessions while the remaining respondents attended 5 or more sessions. The mean of the sessions taken stands at 4.4. It appears that most respondents would prefer taking the minimum allowable counselling sessions. One explained this scenario as follows:

> *"I am the sole bread winner of my family. There are many pressing needs and I need to provide daily. I would rather finish counselling soonest." [PHC/A1/25].*

***Decision to Seek for a Psychotherapist***

Respondents needed to indicate if they were assisted in making decision seeking psychotherapy services or it was own decision. Table 5 below indicates their feedback.

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**Table 5: Making the Decision to Seek Psychotherapy Services among Respondents**

| Assisted to make the decision | f | % |
|---|---|---|
| Yes | 15 | 22.0 |
| No | 53 | 78.0 |
| **Total** | **68** | **100.0** |

From Table 5, only a fifth of the respondents made the decision on their own while the majority were assisted to do so. This demonstrates the lack of understanding and need for counselling services when even one is in need. One respondent wondered:

> *"Is there any financial benefit after the sessions? What I need is money and I am not sure if there will be something in return, I may not be interested. Someone, kindly tell me." [PHC/1K/11].*

**Respondents' Experience after Attending Psychotherapist Sessions**

Respondents were asked if they attended psychotherapy sessions, to indicate their experiences thereafter and if there had been any improvement. This was important in determining if indeed these sessions and service had an impact.

***a. Experience of Greater Self-acceptance and Self-esteem***

The feedback is summarized in Figure 5 below.

**Figure 5: Impact of Psychotherapy on Self-acceptance and Self-esteem Among Respondents**

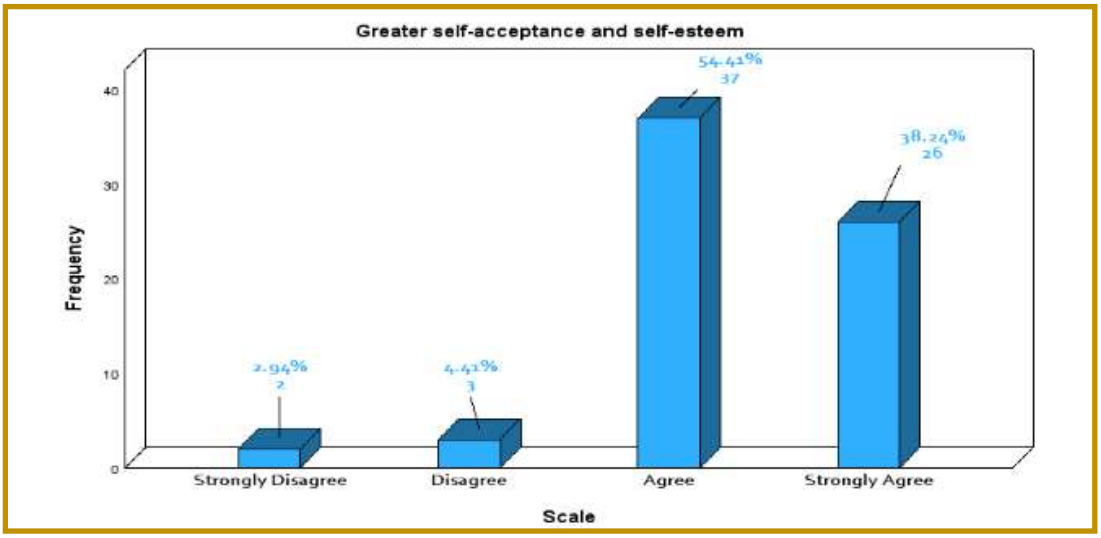


Figure 7 reveals a clear majority concurred with the statement there was greater acceptance and self-esteem after the sessions. On the other hand, less than a tenth disagreed. It was therefore established that most of the respondents experienced greater improvements in self-acceptance and self-esteem. One respondent he looked excited of their experience noted:

> *"It indeed helped me to understand myself. I regret having not discovered it early enough." [PHC/A1/19].*

***b. Ability to Change Self-Defeating Behaviour Among Respondents***

Table 6 below summarizes responses obtained:

 

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**Table 6: Experience of Change in Self-Defeating Behaviour Among Respondents**

| Feed back | f | % |
|---|---|---|
| Strongly Disagree | 2 | 3.0 |
| Disagree | 2 | 3.0 |
| Agree | 42 | 62.0 |
| Strongly Agree | 22 | 32.0 |
| **Total** | **68** | **100.0** |

Table 6 shows nearly all the respondents concurred that there was change in self-defeating behaviour. Only a few respondents did not agree. Great change was experienced by over 94% in handling self-defeating behaviours. One respondent comment that: *"I now think I am a live again. I can do a number of things I could not" [PHC/2K/21].*

***c. Ability to Manage Emotions/Expression after Psychotherapy Services***

On overall, establishing experience on managing emotions/expressions after the psychotherapy sessions was important. Figure 6 below summarizes in graphical presentation responses received:

**Figure 6: Management of Emotions/Expression Among Respondents after the psychotherapy Sessions**

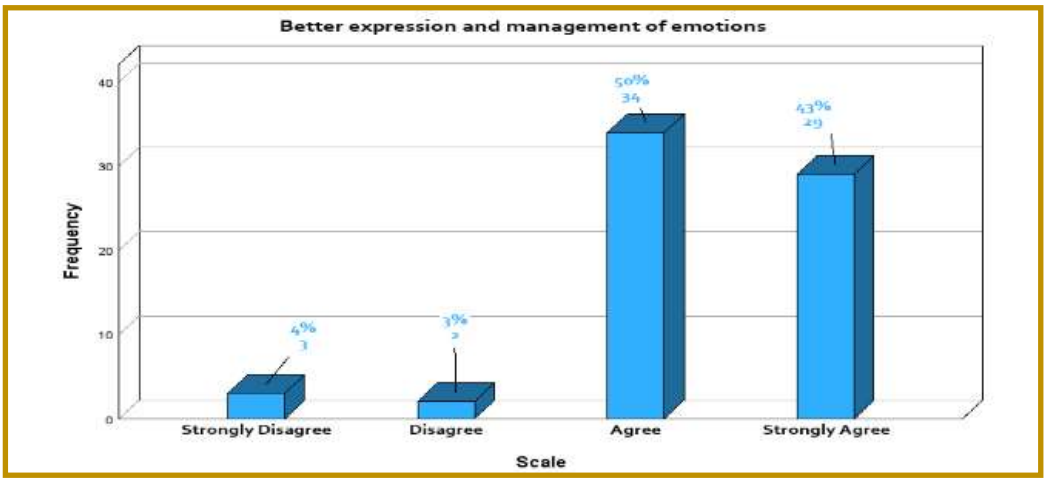


Figure 6 shows nearly all the respondents concurred that respondents experienced improved management of emotions/expressions after the sessions. Only a few respondents did not agree. It implies that most of the respondents experienced change in managing emotions/expressions after psychotherapy, which is a good indication.

*… "I now can control myself after the assistance I received. I am much stable now." [PHC/M1/25].*

***d. Whether Respondents Relieved from Depression or Anxiety on taking the sessions***

The study critically expected to establish whether the sessions assisted in relieve from depression or anxiety. Table 7 below summarizes responses received:

**Table 7: Experience Relieve from Depression or Anxiety Among Respondents after psychotherapy**

| Feed back | f | % |
|---|---|---|
| Strongly Disagree | 2 | 3.0 |
| Disagree | 2 | 3.0 |
| Agree | 37 | 54.0 |
| Strongly Agree | 27 | 40.0 |
| **Total** | **68** | **100.0** |

 

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Table7 shows nearly all concurred to receiving relieve from depression or anxiety after psychotherapy. Only a few did not benefit from the relieve. It implies that most of the respondents experienced relief from depression or anxiety on taking the psychotherapy sessions.

> *"Unlike before I have a piece of mind. I feel in charge of my life." [PHC/A1/24].*

***e. Whether Respondents' Confidence and Decision-Making Skills Improved After the Sessions***

Further, it was essential establishing whether there was an improvement in confidence and decision-making skills after psychotherapy. Graphical presentation Figure 7 below summarizes the responses received:

**Figure 7: State of Confidence level and Decision-Making after Psychotherapy Sessions**

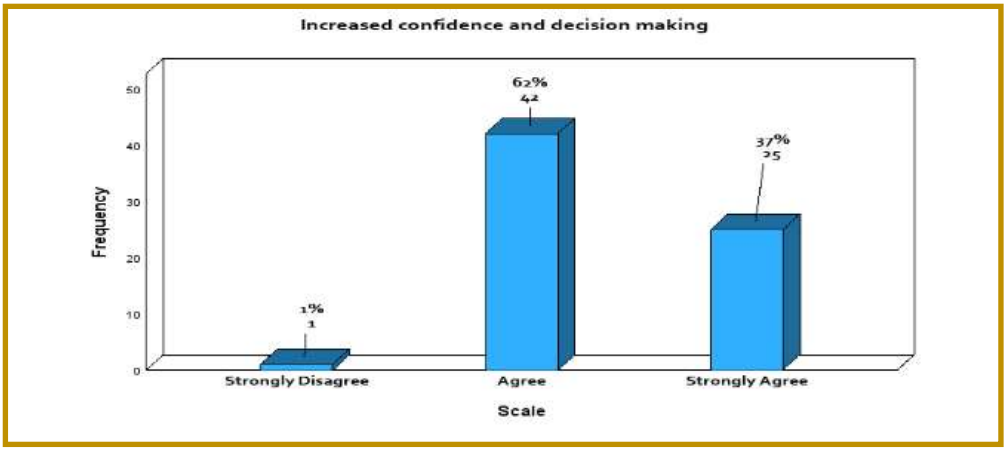


Figure 7 depicts nearly all concurred that respondents gained confidence and decision-making after the session. Therefore 99% of the respondents who utilized psychotherapy experienced increased confidence and decision-making capability. This looks like one aspect that was properly addressed by the psychotherapy sessions. One respondent owned up as follows:*" I do not believe that people can listen to me and learn from my action. I can see a lot of differences now [PHC/G1/32]".*

***f. Stress Management among Respondents who Saw a Psychotherapist.***

Further, there was need establishing whether sessions assisted in management of stress among respondents after their psychotherapy sessions. Table 8 below summarizes responses received:

**Table 8: Whether Psychotherapy Improved Stress Management Among Respondents**

| Feed back | f | % |
|---|---|---|
| Strongly Disagree | 1 | 1.0 |
| Disagree | 0 | 0.0 |
| Agree | 39 | 57.0 |
| Strongly Agree | 28 | 42.0 |
| **Total** | **68** | **100.0** |

Table 8 shows nearly all concurred that psychotherapy improved stress management among the respondents. Therefore 99% of the respondents who utilized psychotherapy experienced improved stress management. This aspect was also properly addressed by the psychotherapy sessions.

> *"…My mind is settled, and my health improved. I am no longer taking drugs to relieve myself as I used to do [PHC/A1/20]".*

**Correlation Analysis**

Stigmatization is proxied by thought patterns, Behaviour, and emotional reaction of respondents. The Pearson correlation coefficient

 

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depicts strong association and direction of linear correlation between psychotherapy and SS. The data presented in the table below reveals the Pearson correlation coefficient between psychotherapy and thought patterns, behaviour, and emotional reaction variables.

**Table 9: Pearson Correlation Coefficient**

| | | Pychotherapy | Thought Patterns | Emotional Reactions | Behaviour |
|---|---|---|---|---|---|
| Psychotherapy | Pearson Correlation | 1 | .455** | .310** | -0.039 |
| | Sig. (1-tailed) | | 0.000 | 0.005 | 0.376 |
| | N | 68 | 68 | 68 | 68 |
| Thought Patterns | Pearson Correlation | .455** | 1 | .483** | 0.094 |
| | Sig. (1-tailed) | 0.000 | | 0.000 | 0.223 |
| | N | 68 | 68 | 68 | 68 |
| Emotional Reactions | Pearson Correlation | .310** | .483** | 1 | -0.090 |
| | Sig. (1-tailed) | 0.005 | 0.000 | | 0.233 |
| | N | 68 | 68 | 68 | 68 |
| Behaviour | Pearson Correlation | -0.039 | 0.094 | -0.090 | 1 |
| | Sig. (1-tailed) | 0.376 | 0.223 | 0.233 | |
| | N | 68 | 68 | 68 | 68 |

The data in the table above reveals a positive linear correlation between psychotherapy and emotional reactions (r = 0.46, p = 0.000), as well as thought patterns (r = 0.31, p = 0.005) at a significance level of 0.01. In contrast, there is no linear relationship between psychotherapy and behaviour (r = -0.04, p = 0.376) at the 0.01 significance level.

It's worth noting that the positive correlation coefficient between psychotherapy and emotion reactions indicates a direct positive effect of psychotherapy services on emotional reactions. In other words, respondents' emotional reactions tend to improve as they seek psychotherapy services. Similarly, the positive correlation coefficient between psychotherapy and thought patterns suggests an improvement in respondents' thought patterns as they attend psychotherapy sessions. Conversely, the negative correlation coefficient between psychotherapy and behaviour suggests that unethical behaviour tends to decrease as respondents attend psychotherapy sessions.

## DISCUSSIONS

The effects of HIV globally remain huge. PLWH both at individual and family levels face escalating poverty attributed to their loss of income, raising medical sustenance as well as death. The great sufferings associated with HIV has elicited consented responses internationally towards alleviation of the effects. This study focused on the relationship between psychotherapy and mitigating SS that happens when one is aware of their HIV positive status. It did not test the other factors that would help mitigate effects of SS among PLWH.

They also did not actively seek for counselling services nor support groups. Finally, on the desire and uptake of counselling services in line with objective five, nearly 50% of the respondents felt a need for psychotherapy services, with only 27% reporting seeking the service. Of this, over 75% only attended minimum number of sessions between 3 and 4. This well explains assertions that most PLWH are reluctant in seeking professional help to manage stigmatization which in turn fuels the HIV infections. Over 92% of the respondents concurred that after their sessions, they experienced great improvements in decision making, self-acceptance and esteem, handling self-defeating habits, expression and managing of emotions, relief from depression, stress, anxiety among others. Statistically, the Pearson correlation coefficient established strength and direction of linear correlation between psychotherapy and SS.

This endorses the work of Krause *et al*. (2015) asserting that therapeutic change is expected as clients work on their problems, gain understanding, achieve personal satisfaction, and

 

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become self-dependent. This process transforms their problems and symptoms, self-awareness, and interaction in the environment they find themselves. 95% of the respondents indicated that they recommended psychotherapy to PLWH as it would help them live a dignified life. SS is well manifested in the underlying aggression and preceding stigmas incentivize control of stigmatizers, resulting in more intense stigmatization when internalized. Given similarities in the feelings of PLWH regardless of their set-ups, the result of this work is symbolic. The anticipated change from psychotherapy is well explained by social cognitive theory. It could be necessary to extend the work to find out relevancy in children especially the adolescence.

## CONCLUSIONS

The study confirmed that only a few PLWH felt the need to seek psychotherapy services, with the number being smaller for those who accessed the service, majority of whom were assisted to make the decision. Those who did only attended the minimum sessions being between 3 and 4 which on overall seemed sufficient. The study further confirmed that the sessions were very impactful from the experience of those who attended. They testified to have had remarkably improved post sessions on decision making, self-acceptance and esteem, handling self-defeating habits, expression and managing of emotions, relief from depression, stress, anxiety among others. When the PLWH were asked if they would recommend psychotherapy to their peers experiencing SS, they were resounding affirmative that this could help.

### Implications of the Findings

With the established prevalence of SS among PLWH, authorities with all stakeholders need to boosting efforts to counter the prejudice associated with one being labelled a PLWH. Laws that ensure there is fair treatment of PLWH should consistently be reviewed and implemented. The High-risk groups such as MSM in the society need to be accommodated and reformed as far as is possible. Further, jurisdictions should consider reviewing laws, rules, policies and procedures fuelling stigmatization especially those obligating practices such as screening before admission to institutions of learning, job recruitment, travel, eligibility for services such as insurance and social security benefits. Strict enforcement must be observed so that PLWH are not unfairly regarded. In certain cases, HIV prevention, management and wellness services are not available adequately to PLWH. It is also anticipated that relevant authorities shall take steps of implementing policies that support adoption of psychotherapy alongside other measures taken to minimize SS among PLWH. They need to find ways to ensure there are adequate service providers to reach PLWH. If this is done, there is hope to reduce the impact of the HIV menace.

### Recommendation

From the study findings and summary, it is recommended that:

- Authorities intentionally prioritize and entrench use of psychotherapy especially in managing SS among PLWH. For this to succeed, availability of this service needs to be enhanced at the grass root level, perhaps in relevant public health facilities, and equally made affordable to those who require it especially in less developed setups. This should also come with sensitization of the masses on the opportunity and the benefits of psychotherapy. There should be efforts to make the relevant curriculum that produce psychotherapist much customized so that the service made available is fit for purpose. This service should be applied alongside the other measures being taken to support PLWH.
- Much efforts be extended towards sensitizing the “family” on their significant role in supporting PLWH instead of humiliating and labelling them due to misconceptions about HIV perpetuated fear and judgement against PLWH. Families need to understand it does not help snubbing seropositive members, linking them to same sex activities, drug abuse or immorality. Instead, they would live

 

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a normal life if they were supported to receive the care they need and being embraced by the society. Infact, this would help to reduce some incidences that spread the disease.

- More emphasis needs to be enhancing and sustaining advocacy work on implementation of international agreements and treaties signed between nations in relation to HIV prevention and management. This includes the International Labour Organization (ILO) HIV Recommendation, 2010 (No. 200), Global Partnership for Action, Global AIDS Strategy (2021-2026). Globally, attention shifted to new and emerging issues especially, insurgence of COVID-19 in 2020 to 2022, environmental degradation and geopolitical shocks that affect macro-economic environment that impact human life adversely.

- Rather than shrink the resources towards eradication of HIV-related stigmatization, more opportunities should be exploited to enhance the outreach and the intensity in preventing and management of HIV/AIDS. When structuring support programmes, PLWH should be involve at all levels so that their set-ups and needs are well understood to maximize benefits to them. Given heavy prevalence in the young adults, initiatives emphasizing skills-building especially those just tested HIV positive could be effective in reducing internalized stigma.

**Recommendations for Further Study**

In terms of gaps in our knowledge of how to reduce SS, further work can be done.

- Interventions to reduce HIV/AIDS and the related stigma in less developed nations.

- Studies on the significance of psycho support in managing HIV-related stigmatization.

- Relationship between the other forms of HIV-stigmatization and SS.

- Availability and utilization of psychotherapy services in managing stigmatization in a developing country.

- Whether SS is prevalent children and the best ways of mitigating such stigmatization.

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