

THE PSYCHOSOCIAL STRESSORS OF WOMEN WITH HIV/AIDS

INVOLVED IN A SUPPORT GROUP (in Walvis Bay)

REINETT FREYA FERIS

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Study leader: Prof. Sulina Green

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

SUMMARY

An exploratory study was conducted to determine the psychosocial stressors of women living with HIV/AIDS. The study also included the utilisation of group work by social workers to support HIV positive women. The exploratory study was also conducted to determine HIV positive women's experiences in a support group.

The researcher's interest in group work, as well as her involvement with a support group with HIV positive women, is the motivation for the study. The aim of the study is to provide an explanation of the psychosocial stressors that HIV positive women experience and also to capture their experiences regarding the support group they attend.

Nine psychosocial stressors, namely anger, fear, loss, grieve, guilt, denial and disclosure, depression, suicidal behaviour and anxiety, were included in the literature study. The advantages, disadvantages and components of group work, as well as comparisons of effective and ineffective groups, were highlighted. The research also focused on planning a group for women with HIV/AIDS, with special attention given to the needs assessment, the purpose of the group, the group composition and the structure of the group. The value of group work with HIV positive women was investigated.

The universum was HIV positive women at the Walvis Bay Multi-Purpose Centre. The qualitative research method that was used took the form of structured interviews. The results of this study generally confirmed the findings of the literature study. Recommendations include ways in which social workers can assist HIV positive women not only on an individual basis but also especially in a group setting, and recommendations concerning future research. The importance of future research with HIV positive women was especially recommended.

OPSOMMING

'n Verkennende studie is onderneem om die psigososiale stresfaktore wat HIV positiewe vroue ondervind, te bepaal. Die studie het ook maatskaplike werkers se gebruik van groepwerk om HIV positiewe vroue te ondersteun, ondersoek. Die navorsing is voorts onderneem om HIV positiewe vroue se ervarings van 'n ondersteunersgroep te bepaal.

Die navorser se belangstelling in groepwerk, en haar betrokkenheid by 'n ondersteunersgroep vir HIV positiewe vroue, was die motivering om die studie te onderneem. Die doel met die studie is om die psigososiale stresfaktore wat HIV positiewe vroue ondervind, te beskryf en te verduidelik, en ook om sommige van die ervarings wat sulke vroue in 'n ondersteunersgroep ondervind, te boekstaaf.

Nege psigososiale stresfaktore, naamlik woede, vrees, verlies, droefheid, skuldgevoel, ontkenning en onthulling, depressie, selfmoordgedrag en angs, is in die literatuurstudie bestudeer. Die komponente en voor- en nadele van groepwerk, asook 'n vergelyking van effektiewe en oneffektiewe groepe is ook ingesluit. Die beplanning van 'n groep vir HIV positiewe vroue is benadruk, met spesiale verwysing na die behoeftebepaling, en die doel, die samestelling en die struktuur van die groep. Die waarde van groepwerk vir HIV positiewe vroue is ook ondersoek.

Die universum is HIV positiewe vroue by die Walvisbaai Multi-Purpose Centre. Die kwalitatiewe navorsingsmetode wat gebruik is, is gestruktureerde onderhoude. Die resultate van die studie het in die algemeen die bevindinge van die literatuurstudie onderskryf. Aanbevelings sluit in wyses waarop maatskaplike werkers HIV positiewe vroue nie alleen op 'n individuele basis nie, maar ook in groepsverband kan ondersteun, asook moontlike gebiede vir verdere navorsing. Die belang van verdere navorsing met HIV positiewe vroue word veral beklemtoon.

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CHAPTER 1

INTRODUCTION

1.1	Motivation for the study	1
1.2	Aim and objectives	3
1.3	Demarcation of the study.....	3
1.4	Research methodology.....	3
1.4.1	Literature Review	3
1.4.2	Research method.....	4
1.4.3	Sampling and data gathering	4
1.5	Limitations of the study	5
1.6	Content.....	5

CHAPTER 2

PSYCHOSOCIAL STRESSORS EXPERIENCED BY HIV POSITIVE WOMEN

2.1	Introduction	6
2.2	Kinds of psychosocial stressors	7
2.2.1	Anger	7
2.2.2	Fear	9
2.2.2.1	Fear of impairment.....	10
2.2.2.2	Fear of uncertainty	10
2.2.2.3	Fear of stigmatisation	10
2.2.2.4	Fear of sexuality	11
2.2.2.5	Fear of disclosure	11
2.2.2.6	Fear of death.....	11
2.2.3	Loss.....	12
2.2.4	Grief.....	13
2.2.5	Guilt.....	15
2.2.5.1	Shame	15
2.2.5.2	Self-blame	16
2.2.5.3	Remorse.....	17

2.2.6	Denial and disclosure.....	17
2.2.6.1	Spouse/partner.....	19
2.2.6.2	Friends.....	19
2.2.6.3	Doctors and dentists.....	19
2.2.6.4	Social workers, psychologist, therapist.....	20
2.2.6.5	Sex partners and one-night stands.....	20
2.2.6.6	Parents.....	20
2.2.6.7	Siblings and close family.....	20
2.2.6.8	Co-workers.....	21
2.2.7	Depression.....	21
2.2.8	Suicidal behaviour.....	23
2.2.9	Anxiety.....	25
2.3	Conclusion.....	26

CHAPTER 3

THE UTILIZATION OF GROUP WORK BY SOCIAL WORKERS TO SUPPORT HIV POSITIVE WOMEN

3.1	Introduction.....	27
3.2	Definition of social group work.....	29
3.3	Advantages and disadvantages of social group work.....	30
3.3.1	Advantages of social group work.....	30
3.3.2	Disadvantages or limitations of group work.....	32
3.4	Components of group work.....	34
3.5	Comparison of effective and ineffective groups.....	35
3.6	Elements of the group work process.....	37
3.6.1	Planning a group for women with HIV/AIDS.....	38
3.6.1.1	Needs assessment.....	38
3.6.2	Purpose.....	39
3.6.3	Content.....	41
3.6.4	Composition.....	41
3.6.5	Structure.....	43
3.7	Conclusion.....	44

CHAPTER 4**A SITUATION ANALYSIS OF PSYCHOSOCIAL STRESSORS FOR WOMEN
LIVING WITH HIV/AIDS AND THE EXECUTION OF GROUP WORK TO ASSIST
IN THE EMOTIONAL NEEDS OF THESE WOMEN**

4.1	Introduction	45
4.2	Empirical study	45
4.2.1	Research method	45
4.3	Results of the investigation	46
4.3.1	Identifying information.....	46
4.3.1.1	Age of respondents	46
4.3.1.2	Marital status	47
4.3.1.3	Number of children of respondents	47
4.3.1.4	Respondents' highest qualification	48
4.3.2	Background prior to the discovery of HIV positive status	49
4.3.3	Psychosocial stressors experienced after discovery of HIV positive status	52
4.3.3.1	Anger	52
4.3.3.2	Fear	56
4.3.3.3	Loss.....	58
4.3.3.4	Grief.....	60
4.3.3.5	Guilt.....	63
4.3.3.6	Denial and disclosure.....	64
4.3.3.7	Depression.....	65
4.3.3.8	Suicidal behaviour	66
4.3.3.9	Anxiety.....	68
4.3.4	Information regarding the support group.....	69
4.3.4.1	The respondents' experience of the support group	69
4.4	Summary.....	72

CHAPTER 5**CONCLUSIONS AND RECOMMENDATIONS**

5.1	Introduction.....	73
5.2	Conclusions.....	73
5.2.1	Identifying information.....	73
5.2.2	Background regarding discovering of HIV status	74
5.2.3	Psychosocial stressors.....	74
5.2.3.1	Anger.....	74
5.2.3.2	Fear.....	74
5.2.3.3	Loss.....	75
5.2.3.4	Grief.....	75
5.2.3.5	Guilt.....	76
5.2.3.6	Denial and disclosure	76
5.2.3.7	Depression	76
5.2.3.8	Suicidal behaviour.....	77
5.2.3.9	Anxiety	77
5.2.4	Experience of involvement in group work	77
5.3	Recommendations.....	78
5.3.1	Anger	78
5.3.2	Fear and loss	78
5.3.3	Grief.....	78
5.3.4	Guilt.....	78
5.3.5	Denial and disclosure.....	78
5.3.6	Suicidal behaviour	79
5.3.7	Anxiety	79
5.3.8	The role of the social worker.....	79
5.4	Areas for further research	79
	BIBLIOGRAPHY	80

ANNEXURE A: Written consent for respondent

ANNEXURE B: Questionnaire for HIV positive women

LIST OF TABLES

Table 3.1:	Approaches and techniques for achievement of purpose of group.....	40
Table 4.1:	Age of respondents	46
Table 4.2:	Marital status	47
Table 4.3:	Number of children.....	48
Table 4.4:	Counselling before HIV testing.....	51
Table 4.5:	Anger experienced after HIV positive results	52
Table 4.6:	Different fears experienced.....	57
Table 4.7:	Stages of grief.....	61
Table 4.8:	Guilt experience by respondents.....	63
Table 4.9:	Disclosure	64
Table 4.10:	Suicidal behaviour	67
Table 4.11:	Environmental triggers	68
Table 4.12:	Anxiety	68
Table 4.13:	Experiences of support group	70

LIST OF FIGURES

Figure 3.1:	Components of an effective group, cooperation and competition.....	34
Figure 4.1:	Highest qualification.....	48
Figure 4.2:	Manner of detection.....	49
Figure 4.3:	Suspicion of being HIV positive	50
Figure 4.4:	Kinds of loss	58
Figure 4.5:	Depression	66

CHAPTER 1

INTRODUCTION

1.1 MOTIVATION FOR THE STUDY

There is currently grave concern about the growing number of women with HIV/AIDS. This number increases almost daily, according to statistics by UNAIDS (1997). Almost four-fifths of all women infected with HIV live in Africa. For every six women who are infected, only five men test positive, and in the 15–24 year age group, young women outnumbered men by 2:1 (Tallis, 1998:9). Malherbe (2002:337) is also concerned about the growing number of women with HIV/AIDS, stating that women are especially vulnerable to becoming HIV positive. Women comprise 52% of the adult population of Africa. According to UNAIDS (2001:1) women are becoming infected at a significantly younger age: half of them are younger than 25 years of age. Petersen (1995:1325) also shares this concern and states that women who are diagnosed with AIDS die six times faster than men.

It is known that AIDS cannot be cured, but it can be prevented. Although the question might be why a preventable disease is spreading so rapidly and killing women in such large numbers, time should be invested to study the everyday lives of women living with HIV/AIDS (Laird, 2001:260). Laird (2001) agrees with Peterson (1995:1325) and states that programs and efforts to curb the spread of HIV/AIDS amongst women are mostly in vain because these only focus on general preventative measures and do not deal with infected women's realities such as anger, loss, anxieties and guilt. It is therefore necessary for social workers to shift the emphasis from curing and curbing to caring and assisting.

The HI-virus is mostly spread through unsafe sexual practises. Because of their traditional roles women are more defenceless against HIV infection than men (Tallis, 1998:6).

HIV positive women experience a lot of psychosocial stress in their everyday lives. Owens (2003:163) describes stress based on Monat and Lazarus's (1991) transactional model. According to her, a person will feel stressed when an event or situation is experienced as stressful, and they do not have any coping strategies to deal with stress symptoms. An example of the psychosocial areas of stress that a person can experience can be taken from the following extract. When Critzer (2002:1-2) found out that he was HIV positive, he was totally

shocked. Most of the psychosocial stressors that will be discussed are captured in the following extract:

*"I went completely numb. I had suspected that something was wrong with my health since May of that year when I had the worst flu of my life. It left me too weak to stand, which no illness had ever done. Six weeks later half the hair on my head fell out. I freaked out. Luckily it all grew back. A month later I develop painful sores in my mouth during extreme job stress. Then I summoned up enough courage to take an HIV test after two more months and then was told that I was HIV positive. I immediately started projecting my own death, a horrible, ugly, lonely fate that could start at any moment. Eventually I had worked myself up to a point where I was contemplating ending my own life. Suddenly the notion of doing anything long-term seemed ridiculous. Soon I turned to anger. I was **angry**. I had no idea what to do next. I was full of conflict."*

When people experience stress they need support. This also applies to women with HIV/AIDS. The feelings reflected in this quote (Critzler, 2002:1-2) are disbelief, denial, anger, fear, loss and suicidal thoughts. These are the same psychosocial stressors that HIV positive people experience when diagnosed with HIV/AIDS. The question can be asked what HIV positive women would recognize as supportive aspects that can help them to cope with HIV/AIDS. According to Owens (2003:145-169) it is important for social workers to hear the needs and experiences of HIV positive women *in their own voice*, in order to assess what they experience as support. Social workers have to be sensitive to the psychosocial stress that HIV positive women experience and therefore should allow them to share their experiences in their own voice.

Social workers can do case work and group work to assist HIV positive women with their psychosocial stressors. The researcher is presently involved in group work and is therefore interested to explore the use of it to help HIV positive women. Considering that social workers have always been in the vanguard in advocating for the needs of the oppressed and the disadvantaged, it is imperative that social workers not only comprehend this phenomenon of HIV positive women but also be equipped with method, technique and strategy to deal with the HIV positive female client, in her entirety, in a group. Only when social workers have significant training in the field of HIV/AIDS, will they be able to address these issues more

effectively and efficiently, which will ensure meaningful, long-lasting change for and empowerment of women living with HIV/AIDS.

1.2 AIM AND OBJECTIVES

The aim of this study is to provide an explanation of the psychosocial stressors experienced by HIV positive women, and a description of their experiences of their involvement in a support group.

The following objectives have been formulated:

- to describe the nature and impact of psychosocial stressors which HIV positive women experience
- to explain how group work can be used to support HIV positive women.

1.3 DEMARCATION OF THE STUDY

This study was conducted in Walvis Bay, Namibia, amongst a support group for HIV positive women. The first HIV positive person in Walvis Bay that disclosed her HIV status publicly was Maureen Katjitako. When she discovered that she was HIV positive in 2001, she started a support group at the Walvis Bay Multi-Purpose Centre in May 2001. She died in 2002, but this support group is still functioning. Many of its original members have died since. Today many of the existing members are sick and some are on anti-retroviral treatment. Most of the members are not employed. The group consists of sixteen members of which ten constantly attend the group sessions. The rest attend as their health allows. It is also the only HIV support group in Walvis Bay, a harbour town with a population of about 45,000 individuals (2002). The prevalence of HIV is estimated at 21% of the present population.

1.4 RESEARCH METHODOLOGY

The research methodology can be divided into three categories, namely the literature review, the research method and data gathering instruments.

1.4.1 Literature review

Current literature dealing with HIV positive women was reviewed. Study materials were obtained from the J.S. Gericke Library and the Erica Theron Reading Room at the University

of Stellenbosch. Books were obtained from Family Health International in Windhoek and from the Walvis Bay Library.

1.4.2 Research method

For the purpose of this study an exploratory design is employed because of the limited information about women and HIV/AIDS and the psychosocial stressors they experience, like anger, fear, loss, grief, guilt, denial and disclosure, depression, suicide and anxiety. Wellman and Kruger (2001) classify the goals of exploratory designs as the exploration of a relatively unfamiliar research area or the studying of cases that do not fit into particular theories.

Qualitative research methods are utilised. Manchall and Rossman (1989:21-22) state that qualitative research is a plan to systematically ask questions to bring a better understanding to the issue. De Vos and Fouche (1998:7) agree with this statement, adding that in qualitative research, questions and problems for research mostly come from real world observations, dilemmas and questions. To discover answers to important questions, processes and relationships, and not to test them, is one purpose of the qualitative method (De Vos & Fouche, 1998:104).

Written consent was obtained from the participants to record interviews, since qualitative research is based on meaning expressed through words and not with methods and techniques.

1.4.3 Sampling and data gathering

The study population consists of ten HIV positive women in Walvis Bay, Namibia who are currently in a support group, attending support group meetings and meetings of an income generating group twice weekly at the Multi-Purpose Centre. Family Health International funds this centre. Only six members were interviewed to make provision for those that might become ill or die.

The sampling is therefore purposive. Grinnell and Williams (1990:230) explain that purposive sampling is used when it is necessary to choose a particular sample of some kind. These samples are not random and are chosen with a specific purpose. Personal interviews were held with these women (after their written consent was obtained) to explore the psychosocial stressors related to their health status. The interviews were aimed at gaining information about the respondents' identity, background to the illness, reasons why respondents had themselves tested, emotions when the results of tests were made known, the personal affects of the

tested, emotions when the results of tests were made known, the personal affects of the problem, the current most serious physical problem, the current most serious emotional problems and psychosocial stressors, and the nature of their support systems. The group members' experiences regarding the support group they attend were also covered.

1.5 LIMITATIONS OF THE STUDY

The literature review indicates that research material, especially books on HIV/AIDS and women, might not be so easily available. Since only relatively little literature was available, indirectly related literature was also included in this study. Another limitation was the lack of recent literature on the topic of social group work.

1.6 CONTENT

The study is divided into five chapters. Chapter Two offers an overview of HIV positive women and the psychosocial stressors they experience such as anger, fear, loss, grief, guilt, denial and disclosure, depression, suicide and anxiety. In Chapter Three a description of how group work can be utilized by social workers to help with HIV positive women is offered. Chapter Four consists of a situational analysis of psychosocial stressors of HIV positive women. In Chapter Five conclusions and recommendations are discussed.

CHAPTER 2

PSYCHOSOCIAL STRESSORS EXPERIENCED BY HIV POSITIVE WOMEN

2.1 INTRODUCTION

"Stressful experience" is the mismatch between the demands put on an individual in a challenging situation and his or her ability to address the situation by adequate responses (Siegrist, 2002:299). Anger, fear, loss, grief, guilt, denial and disclosure, depression, suicide and anxiety are some of the psychosocial stressors that affect physically healthy people when there is an inability to deal with stressful situations. Coupled with a deadly disease like HIV/AIDS these stressors are compounded in the lives of HIV positive women and therefore need to be addressed by social workers.

When women have to testify about their HIV status, it is mostly about how their lives changed after they learned about their positive status and how they coped with the idea of being infected. They are confused and question their whole existence and are concerned about close relationships and especially about the future of their children and families. Many HIV positive women are angry with or blame themselves for becoming HIV infected (Van Dyk, 2001:257). All these stressors magnify in their effect when people are ill or when they are in situations where they have no control.

For the purpose of this research it is important to define the terms HIV/AIDS and psychosocial stressors. The *Webster Encyclopaedia* (1989) describes Acquired Immune Deficiency Syndrome or AIDS as an immune system disease caused by a virus known as HIV or Human Immunodeficiency Virus.

The *Webster Encyclopaedia* (1989:1406) defines stress as "any stimulus, as fear or pain that disturbs or interferes with the normal psychological equilibrium of an organism".

Pollitt (1998) states that there is no general consensus on a definition of the term "psychosocial", because for some psychologists and development specialists, psychosocial include only the social and emotional areas, while for others, including Pollitt himself, this term includes not only the social and emotional areas, but also the mental and motor areas of a

person. What is true, however, regardless of what the ideal definition should be, is that all these areas are interrelated.

Many psychosocial stressors have been associated with impairments in the immune system (Antoni & Cruess, 2000:118). Stress lowers a person's ability to fight disease and therefore increases the chances of becoming ill. Berer and Ray (1993:15-16) explains the effect of stress in the case of an HIV positive diagnosis in the following way:

"Once you are told you are HIV positive, there is no such thing as being asymptomatic. You may not have physical symptoms, but your life is forever changed".

In order for social workers to empower and assist HIV positive women effectively, it is imperative for them to have a good understanding of how these women experience psychosocial stressors. In this chapter the focus will be on these psychosocial stressors with specific emphasis on the effect it has on HIV positive women.

2.2 KINDS OF PSYCHOSOCIAL STRESSORS

Various authors like Peterson (1995:1329), Siegrist (2000:300), Strebel (1995:15) and Van Dyk (2001:297) have identified psychosocial stressors that can be experienced by HIV positive women. The nine most common psychosocial stressors mentioned by these authors that will be discussed are anger, fear, loss, grief, guilt, denial and disclosure, depression and suicidal behaviour.

2.2.1 Anger

The first psychosocial stressor that will be discussed and that HIV positive women can experience is anger. According to Van Dyk (2001:297) anger is one of the most common emotional stressors that HIV infected people can experience, but also the least expected by HIV infected people. Critzer (2002:6) views anger like this: "It is the more dangerous emotion because unlike blame that might be stressful, anger can easily turn into hate, either towards yourself or towards others". *The Social Work Dictionary* (1999) defines anger as "a common and usually normal emotion that occurs in response to an individual's perception of being threatened or harmed". Its manifestations often include irritability, physical or verbal attacks, increased heart rates, rage and negativism. Anger may be continuous or intermittent, directed inward or outward, intense or mild and conscious or unconscious. Novaco (2000:188) states

that anger is a negatively toned emotion, which is subjectively experienced as an aroused state of antagonism towards someone or something perceived to be the source of an aversive event. The relationship of anger to stress is three-fold. It is an effective response to survival threats or stressful circumstances, it is a high arousal state and causes wear and tear on the body when it is experienced frequently, and it can be part of a personality style of coping with stresses of daily life. Anger is prototypically experienced as a justified response to some "wrong" that has been done.

Grodeck (2003:9-10), refers to Mark H who states that to feel anger is much easier than to feel shame, guilt, resentment or sadness, because all these stressors hurt, except anger. An HIV positive woman struggles with questions such as "Why me and not someone else who also engaged in risk-associated behaviour?" Life does not seem fair to a woman in that position. The frustration can build up to such an extent that these women blame people they care about. It is also natural to blame a spouse or a partner she suspected might have infected her. In the end she will most definitely find that all her anger is in fact directed towards herself. Anger is described as eruptive, destructive, unbridled, savage, venomous, burning and consuming (Novaco, 2000:189).

Critzer (2002:1) agrees with this, stating that because he was going to die, he felt angry all the time, at all those people around him who were going to keep on living healthy lives while he was dying of AIDS. He felt angry at himself for letting it happen to him, and also at whoever gave it to him.

The attitude of people towards the disease and the disease itself may also activate anger. An HIV positive woman can also experience misplaced anger, especially if she is not aware that she is angry. When an HIV positive woman reports anger experiences, she most typically gives accounts of things that have "happened" to her. HIV positive women have the notion of blaming the anger on the personal, stable and controllable aspects of another person's behaviour.

According to Gifford, Lorig, Laurent and Gonzalez (2000:101-102) on diagnosis, an HIV positive person's future will change, as well as his/her plans and emotions. Loss of control and independence leads to frustrations, helplessness and hopelessness. These feelings fuel anger, and therefore it is normal to feel angry.

According to Van Dyk (2001:257) anger is not always a response to having HIV/AIDS, but can also be the result of the disease process, for example when a certain part of the brain is affected by an infection, the ability to express or suppress emotions becomes difficult. An HIV/AIDS infected person who experiences this kind of infection can appear to cry or have temper tantrums for no apparent reason. To be able to manage anger, HIV positive persons must first recognise and admit that they are angry, and identify with what or with whom they are angry. If anger is not expressed, it can build up until it becomes explosive, offending others. If anger is turned inward, it can intensify or enhance other symptoms, like depression. HIV/AIDS infected women often experience anger directed towards themselves and others. On occasion they direct this anger at the people who are closest to them, like spouses and children. They are angry for numerous reasons. One reason is the absence of a cure for HIV/AIDS. Other reasons could include uncertainty about what lies ahead. Anger is sometimes expressed towards the person who infected them and also directed towards the community's reaction of antagonism and apathy (Van Dyk, 2001:257).

Mthembu (1998:26) resonates the same view, stating that she too was shocked and angered when she first discovered that she was HIV positive. She was from a religious family and only had one sexual partner and never slept around with anybody. Antle, Wells, Goldie, De Matteo and King (2001:164) summarise these feelings of anger like this: *"I am mad all the time and take it out on my children, because I have no where else to put it."*

The social worker should be aware of this psychosocial stressor when she deals with HIV positive women. One of the methods that the social worker can use, that is cost and time effective, is creating groups for women that focus on concerns surrounding HIV/AIDS related support and stressors like anger (Owens, 2003:169). In a group setting anger can be addressed by education about anger, stress and aggression. Situational triggers can be identified and self-monitoring can be practised through role playing as well as breathing focused relaxation (Novaco, 2000:188-194). These are but a few techniques social workers can use to assist HIV positive women in a group session.

2.2.2 Fear

According to a number of authors (Grodeck, 2003:20; Panos Dossier, 1990:50; Sewpaul & Mahlalela, 1998:39; Strydom, 2002:143; Van Dyk, 2001:296), the second psychosocial stressor that HIV positive women experience is fear. *The Social Work Dictionary* (1999:171)

describes fear as "the emotional and physical reaction to an identifiable or perceived source of danger". Barlow and Durant (1999:54) define fear as follows: "an emotion of an immediate alarm reaction to present danger or life threatening emergencies". The emotion of fear is a subjective feeling of terror and this feeling strongly motivates one to behave either by escaping or fighting (fight or flight). When HIV positive women are confronting the realities of HIV/AIDS, it creates a number of fears. These fears can result in severe emotional strain for an HIV positive woman. According to Sunderland and Shelp (1987) as explained by Van Dyk (2001:296-298), the different kinds of fear an HIV positive woman can experience are fear of impairment, fear of an uncertain future, fear of stigmatisation, fear of sexuality, fear of disclosure and fear of death.

2.2.2.1 *Fear of impairment*

The fear of impairment is a very real and justified fear experienced by HIV positive women. When an HIV positive woman admits having an illness, it can create a feeling of inferiority and enhance mortality. To be diagnosed with an illness also results in some degree of isolation because the illness can prevent one from participating in the normal pleasures of social life.

2.2.2.2 *Fear of an uncertain future*

Fear of an uncertain future can be very severe and results in HIV positive women doing anything to gain their previous equilibrium. When a woman is tested HIV positive, all hopes, stabilities, certainties, life plans and ambitions are being threatened. This threat may result in psychological and spiritual regression and deterioration.

2.2.2.3 *Fear of stigmatisation*

The fear of stigmatisation is related to public attitudes towards HIV/AIDS, as the stigma attached to this illness is often linked to promiscuity (Sewpaul & Mahlalela, 1998:34-42). According to Grodeck (2003:20) the word stigma means, "mark of discredit". It is derived from "stigmata", a word which is normally used to describe the wounds resulting from the crucifixion of Christ. HIV stigma refers to discounting and discrediting of and prejudice and discrimination against people who have HIV and anyone associated with them. For an HIV positive woman, HIV stigma could mean denial of ordinary benefits of social life like medical

aid and rejection by friends or even violence towards them. This is a very real fear and causes HIV positive women the most pain. Stigma also fuels personal feelings of shame.

2.2.2.4 *Fear of sexuality*

The fear of sexuality is linked to superstition, mystery, taboos, ignorance and double standards regarding HIV/AIDS and sex, according to Van Dyk (2001:296). A young woman with AIDS, a single woman who has been diagnosed with HIV/AIDS, will find herself in the middle of a kind of "social death" (Panos Dossier, 1990:50). The HIV positive woman cannot marry or make new friends because of the fear of passing the virus on to her partner. When revealing her status to her partner she risks rejection.

2.2.2.5 *Fear of disclosure*

The fear of disclosure means that an HIV positive woman decides to keep her status a secret because of the fear of rejection. It then becomes almost impossible to seek help from the medical profession. The feeling of isolation is the worst thing about being afraid to disclose her HIV status.

2.2.2.6 *Fear of death*

According to Gong (1985:180), as referred to by Strydom (2002:145), the fear of death is a realistic and frightening happening in the lives of AIDS sufferers. Because sickness is very near to death, the expectation of dying creates the same emotional stress as the reality. Strydom (2002:143) conducted a study on the feelings and perceptions of AIDS patients in a South African clinic over a five-month period. Some of the respondents reinforced the notion of fear of death by the following statement:

"I was frightened and did not know what to do - death was suddenly a reality" and "I'm thinking morbid thoughts about death".

HIV positive women may also experience fear of death, because they are ignorant about what is implicated by HIV infections, the ensuing ordeal and death. The women in a support group, according to Sewpaul and Mahlalela (1998:38), were concerned about how they would confront both their own death and the death of their children. According to Van Dyk (2001:256) women grapple with the fear of dying and specifically dying alone and in pain. What makes matters worse is that most HIV positive women are familiar with pain and the

death of loved ones and family members. Subsequently they know and therefore fear what they are going to encounter.

The kinds of fear as described in this section can make HIV positive women live a constricted life (Kübler-Ross, 1995:50-51) and hamper them severely in the decisions and choices they need to make. It is a real emotion experienced by HIV positive women, but they need someone such as a social worker to assist them to deal with this fear preferably in a group setting which will create cohesion and therefore lessen fear.

2.2.3 Loss

The third psychosocial stressor HIV positive women experience is loss, according to Van Dyk (2001:254). These include loss of control, loss of autonomy, loss of ambitions, loss of physical attractiveness, loss of sexual relationships and loss of status and respect in their communities. Van Dyk (2001:254) also states that social workers as well as other professionals consider loss to be the crucial element in crisis and a major precipitator of many forms of depression.

Loss is defined in *The Social Work Dictionary* (1999:282) as "the state of being deprived of something that was once possessed, as a result of death, divorce, disaster or crime". Katie Bias, as referred to by Panos Dossier (1990:46), describes the loss she experienced when diagnosed as HIV positive like this:

"For me one of the most difficult things to deal with has been the fact that we don't have any children. I was in a symposium on loss and grief and I thought I hadn't really lost anyone. But it turns out that loss comes in many forms – and the loss of the ability to have a child is right up there with losing a family member. It's your potential ..."

What Katie Bias experienced corresponds with the above-mentioned definition of loss, because she had the choice to decide whether or not to have children, but after being diagnosed HIV positive, she lost the ability to have children.

According to Van Dyk (2001:294) the first reaction to loss is always denial, and then follows numbness and shock or a feeling of unreality. When a woman is being diagnosed as HIV positive at a very early stage, it is very difficult to come to terms with the diagnosis because of a lack of symptoms. This may cause her to live as though nothing has happened,

encouraging denial. The positive side of initial denial is that it might buffer the intensity of the loss.

One way to deal with loss is to lessen the importance of the loss, or to remove anything that reminds one of the loss, and even avoiding people. The way in which HIV positive women experience loss is not well defined, but may include losing financial security, losing normal and healthy life style, and losing health and dignity (Van Dyk, 2001:294).

HIV positive women fear the loss of their ability to care for themselves. An overriding concern for HIV positive women, according to Sewpaul and Mahlalela (1998:39), is the possible loss of control over bowel functions and being reduced to the level of babies where other people have to nurse them. The fear of loss of control over their ability to care for themselves during the terminal phase of AIDS was so strong that women in the support group began to believe strongly that voluntary euthanasia should be legalised in South Africa. According to Van Dyk (2001:256) their biggest loss is that of their confidence and self worth because of rejection by people who once were their friends. This could happen because of facial disfigurement, physical wasting and loss of strength or bodily control.

Sewpaul and Mahlalela (1998:36) explain that woman find themselves in intolerable situations when they experience stress situations, which may lead to psychosocial deterioration like sudden or profound loss of mobility or the fear of loss of bodily functions, and then the actual pain of loss.

The social worker can assist HIV positive women to come to grips with the losses they are experiencing and those they will experience in future, through bereavement counselling in a group setting. Talking about the loss is the first step to emotional healing. According to Heap (1977:3-10) the alleviating of social isolation, which is typically experienced by women who face losses can be achieved through a support group for women who are HIV positive.

2.2.4 Grief

The fourth psychosocial stressor that HIV positive women can experience is grief, according to Van Dyk (2001:256). They grieve about their losses, their friends and families who have died from HIV/AIDS, and for their loved ones who will be left behind when their time comes, especially for their children (Van Dyk, 2001:256). A women with HIV/AIDS, who was going through the process of anticipatory grieving, was confronted with the deteriorating health of

her HIV positive, four-year-old daughter. What made her pain and distress worse was her child asking for a school bag. The child had a sense of future, while the mother knew there was not one (Sewpaul & Mahlalela, 1998:39).

The Social Work Dictionary (1999:200) defines grief as "an intense and acute sorrow resulting from loss". This emotional response is normal and in healthy people it will gradually subside in a limited time. According to Kübler-Ross (1995:51) grief is a natural emotion and one of the greatest gifts that humans are given, to take care of all the losses in life. Grief is an involuntary, complicated and psychological response to loss or extreme trauma experienced by HIV positive women. It is the process of movement through pain of loss, the process that helps one let go of intense emotional attachments. The experience of grief is very personal and subjective. Grief can be both emotional and physical (Watstein & Stratton, 2003:205). Elizabeth Kübler-Ross (1995) as referred to by Gifford *et al.* (2000:212-213), describes the following stages of grief:

- Shock: When one experiences both a mental as well as a physical reaction when one first hears about the loss.
- Denial: When one denies what is happening and for some time proceeds with life as if nothing happened.
- Anger: When one questions why this happened to you specifically, and then look for someone or something to blame.
- Bargaining: When one starts making deals with oneself, someone else or God, like "I'll never smoke again ..."
- Depression: When the truth finally dawns and one is confronted with deep feelings of sadness and hopelessness.
- Acceptance: When one finally accepts what is happening and decide to deal with the situation by doing what must be done.

HIV positive women who experience loss do not pass through these stages one at a time in an orderly fashion, but might experience more than one stage or go back and forth through these stages. If the process of grief does not occur, these suppressed emotions can cause severe psychosomatic illnesses like depression. According to Van Dyk (2001:297-298) HIV positive

women may sometimes consciously or unconsciously deny themselves the right to grieve openly because of the stigma and secrecy associated with the disease.

Olansky (1962) developed the concept of chronic sorrow, which is persistent feelings of sadness, which HIV positive women experience throughout their lives (Antle *et al.*, 2001:160). These feelings of sadness vary in intensity and are relevant to HIV positive women because HIV/AIDS is a life long condition, starting with the initial positive diagnosis.

Grief is a natural process and should be used by social workers to aid HIV positive women to come to terms with their reality.

2.2.5 Guilt

The fifth psychosocial stressor that HIV positive women experience is guilt, according to Van Dyk (2001:302). Sewpaul and Mahlalela (1998:37) state that HIV positive women experience guilt so severely and acutely that they felt that other people could see right through them as if they are carrying a sign board that shouts, 'I'm HIV positive!' *The Social Work Dictionary* (1999:204) defines guilt as "an emotional reaction to the perception of having done something wrong, having failed to do something, or violating important social norms". The reaction is often loss of self-esteem and a desire to make restitution. To make the distinction between guilt and shame has been and still are very difficult for psychologists, according to Kaufman (1989:25).

There might be numerous real and imaginary or irrational reasons why people have feelings of guilt (Van Dyk, 2001:302). Feelings of guilt include self-blame, shame and remorse for past behaviours. Shame is caused by guilt, shortcomings or behaving improperly and it is a very strong emotion. HIV positive women might experience shame in such a severe degree that it could prevent them from seeking help or talking openly about the HIV infection.

To clarify "guilt", shame, self-blame and remorse is discussed.

2.2.5.1 Shame

Kaufman (1989:17-20) states that shame is felt as inner torment. It is the most poignant experience of the self by the self. Shame is a wound made from the inside, dividing a person from both others and him or herself. The individual whose head hangs or whose eyes lower or

whose gaze is shifted, however briefly, is directly communicating shame. This behaviour is present when a woman is HIV positive and is experiencing shame.

Shame is alienating, isolating and deeply disturbing and paralyses HIV positive women. According to Kaufman (1989:21) there are also typically secondary reactions to shame like fear, distress (the crying response) and rage. Fear of further being shamed has a direct response to the alienating effect, especially when the expression of shame itself becomes shamed.

Distress, (crying) masks shame and rage, which serve as a self-protecting function when one receives life-threatening news about one's health or one's loved ones. In the case of an HIV positive woman to be diagnosed as HIV positive itself can be shameful because it could be an indication of her lifestyle, and sexual preferences she might have, even though many HIV positive women do not live a promiscuous life. HIV positive women live in distress and cry a lot because of sadness or helplessness, and even because they feel angry.

Rage is a direct response to anger not being addressed and comes in the form of general hostility, bitterness, chronic hatred or explosive eruptions. Rage insulates or protects the self and actively keeps others away (Kaufman, 1989:100). Kübler-Ross (1995:52) agrees with this, stating that suppressed anger leads to rage, revenge and hatred. When these feelings are not dealt with it can lead to psychological illness and ill health.

2.2.5.2 *Self-blame*

Kaufman (1989:106) states that self-blame occurs when HIV positive women experience mistakes, failure or mishaps. It is the process in which the self blames the self in an angry unforgiving way for whatever mishap occurred. The attention is not on repairing the mishap, but on determining or identifying who's to blame or whose fault it is.

Self-blame is a common emotion when women are diagnosed as HIV positive (Kaufman, 1989:106). Such a woman might blame herself for not using a condom, even whilst knowing about HIV/AIDS and the risk involved in unprotected sex. She might also blame herself for infecting others. Because blame is about determining whose fault it is, blame can also be transferred or shifted away from the HIV positive woman. She may blame her partner whom she suspects of infecting her. When the HIV positive woman shifts the blame, and with it the responsibility, shame can be neutralised. In some instances the alienating effect can be so

debilitating for the HIV positive woman that she has to shift the blame to someone else. In essence to transfer blame is to transfer shame, although not all blaming is shame-derivative.

2.2.5.3 Remorse

An HIV positive woman will feel remorse throughout the course of her disease because remorse is included in feelings of shame and follows after blame or self-blame. The HIV positive women will feel remorse for her past behaviour or mistakes (Van Dyk, 2001:302-303). It is important that HIV positive woman should understand that it is normal to have regrets about past mistakes. These regrets prevent one from making future mistakes or to enable one situation.

Marcenko and Samost (1999:39) state that HIV positive women have to cope or deal with feelings of guilt about their choices of lifestyle that contributed to contracting the virus. Sewpaul and Mahlalela (1998:37) affirm this, stating that HIV positive women that were interviewed experienced an overwhelming sense of guilt at having passed on a death sentence to their children. These women felt so guilty that they believe people could see their guilt and therefore respond antagonistically towards them.

The challenge, according to Rosetta M, as described in Grodeck (2003:21), is to know when to let go of shame. The social worker can address these feelings of guilt like self-blame, shame and remorse that the HIV positive women experience in a group setting which will also indicate and show these women that what they experience is normal.

2.2.6 Denial and disclosure

The sixth psychosocial stressor an HIV positive woman has is the stress relating to denial and disclosure of her HIV status, according to Van Dyk (2001:304). Denial and disclosure are interlinked. Most HIV positive women go through a phase of denial, which serves as an important protective defence mechanism. This supplies the infected person with time to digest and assimilate the sheer idea of being HIV positive before having to confront the actual situation. Since most HIV positive women fear disclosure because of stigmatisation and perceived or real rejection, very few risk admitting it openly (Sewpaul & Mahlalela, 1998:38). However, after disclosing their status this phase of denial, in most cases, comes to an end. *The Social Work Dictionary* (1999:122) affirms the above, stating that denial is the defence

mechanism that protects the personality from anxiety or guilt by disavowing or ignoring unacceptable thoughts, emotions or wishes.

According to Grodeck (2003:2-8) many newly HIV positive diagnosed people block out this diagnosis completely. About one out of every three persons postpone getting medical advice for at least one year after their diagnosis. Another one in three people avoid seeing a doctor for at least two years or more. Kaufman (1989:103) states that denial is the final line of defence when action strategies fail. It guards the boundary between the self and the environment. In the case of HIV positive women research has shown that women in denial of their HIV status tend to develop the stage of AIDS more rapidly (Grodeck, 2003:2-8).

According to Grodeck (2003:2-8) research also shows that one out of every five people with HIV/AIDS have regrets after telling people about their HIV positive status. After being diagnosed as HIV positive, a person might be very vulnerable emotionally. One study showed that the process of selecting persons to share your HIV status with, is often torturous and creates distress. Indecisiveness about sharing HIV status is also very common.

There are different reasons why HIV positive women may decide to disclose their status. According to Grodeck (2003:66) these reasons may differ from woman to woman and might include the following motives:

- the "right" for others to know
- the need of emotional support from others
- the need to gain access to medical resources and services
- the need for intimacy
- the need for integrity or just to be honest.

All these reasons might be why HIV positive women would have the need to disclose their HIV status. There are advantages and disadvantages attached to disclosing one's HIV positive status. The focus should be what good will come of telling other people about one's HIV status, as well as how it can benefit the HIV positive woman. The following people are most likely candidates to whom an HIV positive woman will disclose her status (Grodeck, 2003:66): a spouse or partner, friends, doctors, dentists and social workers, psychologists and

therapists, sex partners and one night stands, parents, siblings and close family and co-workers. Each one of these possible candidates is discussed with the emphasis on potential benefits and potential risks of disclosure to these people, as the HIV positive woman can never be sure whether it will be in her best interest to disclose her status to others.

2.2.6.1 Spouse/partner

A potential benefit of disclosure to a spouse/partner is to get comfort and support from husbands, wives, boyfriends/girlfriends or long-term partners.

A potential risk is that the spouse/partner might become alarmed about his/her own HIV status, and become stressed and nervous. If the relationship between partners is already strained, the disclosure of the HIV positive status might speed up the termination of the relationship.

2.2.6.2 Friends

A potential benefit of disclosure to friends is the comfort and support they can offer the HIV positive person who is in desperate need of comfort after learning about his/her HIV status. A potential risk of disclosing to friends is that there is a lot of ignorance regarding HIV/AIDS, and that might influence people's reactions when they are informed about HIV status. A friend might at first be comfortable with the news, but later become uncomfortable. There are too innumerable accounts of "friends" disappearing after being informed about the HIV status of a friend.

2.2.6.3 Doctors and dentists

Potential benefits of disclosing to doctors and dentists are that it can be helpful and easy because of medical and professional help available. There is, however, no need to disclose the same information to one's chiropractor. However an informed dentist can assist an HIV positive woman to identify certain health problems, though dentists, like all medical personnel, should use "universal precaution".

A potential risk of disclosing to doctors and dentists can be the risk of losing a degree of privacy. Nurses and other health care professionals might be uncomfortable treating someone having HIV/AIDS. Discrimination is an aspect that further enhances the reluctance to disclose.

2.2.6.4 *Social workers, psychologist, therapists*

Potential benefits of disclosing to social workers, psychologist, therapists includes the immense relief of being able to talk openly to a professional person. An HIV woman might find comfort talking to an objective professional person about issues regarding substance abuse, sexual identity, pregnancy and relationships.

A potential risk of disclosing to social workers, psychologist, therapists can be their lack of experience regarding HIV and related issues. This will result in a lack of comfort or support, lack of guidance and some disagreement, resulting in the HIV positive woman avoiding therapy.

2.2.6.5 *Sex partners and one-night stands*

A potential benefit of disclosing to sex partners and one-night stands comes from having integrity and strength of character to be honest in difficult circumstances. Grodeck (2003:68) summarises like this: "going through life being ashamed about certain aspects of one's life has a funny way of making those aspects of your life truly shameful".

A potential risk of disclosure to sex partners and one-night stands before intimacy is that their behaviour regarding sex will change. Because of ignorance and fear of infection, they might reject such a woman outright.

2.2.6.6 *Parents*

The strengthening of the parent-child relationship, of emotional support, if the woman has a good relationship with her parents.

A potential risk of disclosing to parents is that the news might have a devastating effect on them, resulting in the woman having to educate them. If the relationship with the parents is less perfect, such a disclosure may even make the relationship worse.

2.2.6.7 *Siblings and close family*

A potential benefit of disclosing to siblings and close family is that disclosure to family will make such a woman feel less alone. Some HIV positive women sometimes decide to first tell their brothers and sisters before telling their parents, although research has shown that family

members usually are the last to find out about their family member's HIV positive status, unless there is a strong bond between them.

Potential risks of disclosing to siblings and close family could be ignorance, which is once again the biggest obstacle with family members. A sister might think twice before letting her children play or stay with an HIV positive woman, excluding her from family gatherings especially when her HIV status is supposed to be a secret.

2.2.6.8 Co-workers

A potential benefit of disclosing to co-workers is that if an HIV positive woman is also befriended with her colleagues, they might give her the opportunity to discuss health concerns which are related to her work, and support her in the process.

A potential risk of disclosing to co-workers is that workplaces are known as gossip incubators. Telling a colleague in confidence might lead to rumours and could place the woman's future in jeopardy by denying her promotions and even retrenching her.

Deciding whether to disclose or not often leads to life-changing consequences. The choice to disclose is always and only up to the HIV positive woman. According to Mtembu (1989:27) professionals like social workers could start by training HIV positive women skills to disclose. They should also encourage voluntarily disclosure. This could be done in a support group for women living with HIV where these women can share experiences of disclosure as well as being confronted with denial by fellow support group members.

2.2.7 Depression

The seventh psychosocial stressor HIV positive women experience is depression, which is a normal reaction to HIV/AIDS according to Van Dyk (2001:258). Grodeck (2003:20) states that it is very difficult to recognise depression, because there are different degrees of depression just as there are different degrees of pain. *The Social Work Dictionary* (1999:124) defines depression as "an emotional reaction, which is frequently characterised by sadness, discouragement, despair, pessimism about the future, reduced activity and productivity, sleep disturbances or excessive fatigue and feelings of inadequacy, self-effacement and hopelessness". In some individuals these traits may be mild, intermitted and undetectable by observers but in others they may be constant and intense.

According to Grodeck (2003:20) depression is more than sadness, which is short-lived unhappy feelings that happen as a result of a specific situation. Sadness usually disappears after the situation has been resolved or improves. Depression is a chronic medical condition. It is a potentially dangerous brain chemical imbalance that disturbs the normal function of a person and results in suicide 15% of the time.

Research (Grodeck, 2003:120) has shown that more women than men experience depression. Depression is not a characteristic, it is not laziness or absence of motivation, but an abnormally low level of a brain chemical known as "serotonin", which assists people to cope with or handle stressors from the outside world. Depression can fluctuate. Close relatives and friends normally see this condition as a weakness and do not acknowledge it and therefore do not attempt to deal with the condition. Gifford *et al.* (2000:103) explain that more people take their own lives when they learn about their HIV status because of depression.

In order to get a better mental picture of the depression that HIV positive women experience, Barlow and Durant (1999:80) describes the nature of depression according to the DSM-IV (diagnostic and statistical manual) criteria, as follows:

- Depressed mood throughout the day – It is a deep unrelenting sadness that influences the way one sees one's everyday life.
- Absence or lack of pleasure or interest in almost all activity – According to Grodeck (2003:120) this includes not returning phone calls, not making plans with other people, not exercising and not really caring.
- Weight loss (when not dieting) or weight gain – When people are depressed they either loose weight (stop eating) or gain weight (eat a lot of comfort food).
- Insomnia or hypersomnia nearly every day – When there are persistent changes in one's normal sleeping pattern (sleeping either too much or too little) it may signal depression.
- Psychomotor agitation or retardation – This means restlessness or inactivity. According to Grodeck (2003:121) he would wake up in the morning and lie around in his robe for hours, smoking cigarettes, drinking coffee and never accomplishing much. Then he was late for work.

- Fatigue or loss of energy nearly every day – This can be a constant feeling of heaviness, particularly in the arms and legs.
- Feelings of worthlessness or excessive or inappropriate guilt – According to Grodeck (2003:121) his feelings may become exaggerated far beyond what people without depression would feel in the same circumstances. He was obsessed about the idea of disappointing his parents.
- Diminishing ability to think or concentrate or/and indecisiveness – According to Grodeck (2003:121) most people feel groggy when they wake up. Depressed people may feel as if they cannot shake off this groggy feeling all day long.
- Recurrent thoughts of death – To have thoughts about dying or funeral fantasies are human or normal, but these thoughts become abnormal when they persist over time or grow in seriousness (Grodeck, 2003:120).

HIV positive women, when they are first confronted with their HIV status, may experience depression as described by Barlow (1999:80) as well as Grodeck (2003:120). When one experiences five of the nine symptoms mentioned above every day for at least two weeks, one is likely to have major depression and should seek medical help (Barlow, 1999:80).

The social worker must be aware of these criteria to assist depressed HIV positive women. According to Grodeck (2003:120), as well as Gifford *et al.* (2000:223), an HIV positive person will benefit by joining a support group where these psychosocial stressors like depression can be addressed.

2.2.8 Suicidal behaviour

The eighth psychosocial stressor that HIV positive women can experience, is suicidal behaviour, according to Van Dyk (2002:258). Oquendo and Mann (2000:538) describe suicide as self-inflicted death committed by an individual with the intention to end his or her own life. According to Ackerman (1998:19) and Joan (1986:36) there is no one reason for attempting suicide but rather a combination of complex contributing factors, although one incident can serve as a trigger for a suicide attempt. Some reasons could be to avoid pain and discomposure, to lessen shame and grief or to attempt regaining some form of control over one's circumstances or illness.

Sewpaul and Mahlalela (1998:37) state that 73% of the respondents in a study they conducted had suicidal thoughts, especially shortly after they were diagnosed as HIV positive. These women not only wanted to kill themselves but also their HIV positive babies. One woman describes her suicidal feelings like this:

"Every time I looked at the baby I felt it was a corpse. Every time I saw the baby, I used to think about what it would be like when I am sick and the baby is sick. I used to get up in the morning, sit in front of the house and stare at the tree where I wanted to hang myself." (Sewpaul & Mahlalela, 1998:37)

There are certain environmental triggers that start suicidal behaviours. Linehan and Shearn (1998) have categorised these triggers, which are applicable to HIV positive women. These triggers are lack of social support, negative events and social conflicts. Negative events may include financial difficulties, loss of family members or loss of property. Social conflict may include conflict with parents and organisations or interpersonal conflicts. These triggers may contribute to the timing of the suicide act. Lack of social support can include living alone, marital isolation, lack of close friends or family as well as unemployment.

When an HIV positive woman does not deal with her feelings of anger, on the surface it might appear as self-blame, self-destructive behaviour or, when exceedingly intense anger is experienced, it might materialize as suicidal impulses or intentions (Van Dyk, 2002:258).

Suicide is often the result of mood disorders, but it can still occur in the absence of these disorders (Barlow, 1999:224). Suicidal behaviour can be understood when suicidal attempts (that are not successful) and suicidal ideation (serious thoughts of committing suicide) are clarified.

According to Grodeck (2003:17), unlike in the movies, where suicide is romanticised, suicide is messy, degrading, painful and expensive. When he attempted suicide, all he could remember while having his stomach pumped, was that he didn't want to die. He only wanted somebody to help him. The belief that people who threaten to commit suicide are not actually going to do it, is not true according to Sue, Sue and Sue (2000) as referred to in Van Dyk (2001:278). These authors claim that in 80% of all suicide cases, women gave either verbal or non-verbal behaviour cues about their intentions. More than two thirds of people who commit suicide, made their intent known three months before the act.

According to Van Dyk (2001:278) mood indicators like depression and hopelessness can result in thoughts about suicide among HIV positive women. HIV positive women who are severely depressed do not commit suicide because of their low energy levels. Berman and Jobes (1992:107,109,141) mention that real interpersonal isolation and estrangement or the experience of such feelings could stimulate suicidal behaviour. Van Dyk (2001:278) agrees, stating that women might fantasize about committing suicide, when they do not have social support at the time, when they do not have the ability to cope and when there is a lack of emotional resources.

HIV positive women who are in the later stage of AIDS might commit suicide because of deterioration of health, physical illness associated with pain, disability or disfigurement, a decrease in the quality of life and a feeling that people perhaps want to control their life (Pugh, 1995) as in Van Dyk (2001:278).

A woman who has loved ones who committed suicide is also vulnerable to commit suicide herself. Women also entertain suicidal thoughts before their HIV results are known. Sadness and heightened feelings of anxiety, anger, guilt and shame are some more indicators of suicide. Suicide thoughts and acts happen around the time when a woman finds out her HIV status and again at the last stage of the disease (Van Dyk, 2001:278-279).

All these triggers mentioned above could be related to the HIV positive woman, who experiences lack of social support, loss and conflict. The social worker can assist HIV positive women who lack the support systems and who are suicidal, and help them to view their situations differently by discovering their similarities in a group setting. This also limits isolation (Davies, 1975:38-39; Garvin, 1981:158-159).

2.2.9 Anxiety

The ninth and last psychosocial stressor which HIV positive women experienced that is discussed is anxiety, according to Van Dyk (2001:302). *The Social Work Dictionary* (1999) describes anxiety as a feeling of uneasiness, tension and a sense of imminent danger. When such a feeling occurs within a person with no specific cause in the environment, it is known as free-floating anxiety. When it occurs frequently and interferes with effective living or a sense of well-being or is otherwise maladaptive, it is known as anxiety disorder. Piotrowski (1957:42) defines anxiety as distress or feelings of unease because one is afraid of danger or

misfortune. It is also a state of apprehension that creates tension and can cause mental disorder.

According to Öhman (2000:226) anxiety is closely related to fear. The distinction between these two psychosocial stressors is that anxiety is often imagined, while it is typically real in fear. Women who have a life-threatening disease like HIV/AIDS, often experience anxieties as well as feelings of helplessness. They experience these feelings of helplessness because there is nothing they can do about the disease and its effects while they are also afraid of dying (Van Dyk, 2001:302).

Anxiety has a somatic physiological and psychological side, according to Barlow and Durand (1999:112-116). The physiological aspects of anxiety include disturbed breathing and increased heart activity. The psychological aspects of anxiety include conscious awareness of powerlessness to do anything about the disease or situation, always being aware of the inevitable danger and being alert as if facing an emergency. It is physically exhausting, to be so self absorbed about possible dangers and it might interfere with effective problem solving if the anxiety sufferer is constantly doubtful about the nature of the threat or danger situation. Anxious people always have fear about real or threatened danger.

Social workers need to be aware of anxiety in HIV positive women because for them these anxieties are very real.

2.3 CONCLUSION

This chapter has dealt with the psychosocial stressors of HIV positive women. The study confirms that being HIV positive and a woman produces a life crisis, which requires urgent action. In this chapter nine psychosocial stressors were discussed with the emphasis on how HIV positive women experience these stressors. It is difficult to clearly determine which one stressor is the major cause of concern because all psychosocial stressors are interlinked and cannot be separated when dealing with a person with HIV/AIDS. Social workers can either address these psychosocial stressors women experience on an individual basis, which presents itself as a challenge because of the number of HIV positive women, or in a group setting which lessens isolation at the same time.

The next chapter will deal with ways in which social workers can execute group work with HIV positive women in order to address the psychosocial stressors they experience.

CHAPTER 3

THE UTILIZATION OF GROUP WORK FOR HIV POSITIVE WOMEN

3.1 INTRODUCTION

Social work is a profession that can assist HIV positive women to deal with the psychosocial stressors they are experiencing. When the question is asked how social workers can assist in the needs of HIV positive women, the guidelines presented by Pincus and Minahan (1983) that social work practice is varied in its method (casework, group work or community work), in its orientation (primary, secondary or tertiary prevention) and in terms of the system which it works with (resource system, change system, client and target or action system) can be followed in order to determine which social work method to use. This implies that the onus rests on the social worker to determine the method of intervention. Van Dyk (2000:185) states that with the HIV/AIDS pandemic the world was forced to accept a paradigm shift from curing to caring. Due to the fact that HIV/AIDS is not curable the focus should be on caring for the physical as well as the psychological welfare of the individuals as well as their partners.

One of the methods which is cost and time effective, is creating groups for women that focus on concerns surrounding HIV/AIDS related support and stressors (Owens, 2003:169). Through the group process, social workers can provide information about the subsequent course and treatment of AIDS, and they can assist such a group to develop positive attitudes towards health and educate them about unsafe behaviour and help the HIV positive women to develop their coping skills, management of emotions and intimacy problems (Pinto, 2002:83) as referred to by Malherbe (2002:344).

Social workers who might not desire to work in the sphere of HIV/AIDS, cannot avoid the epidemic because Antle *et al.* (2001:150) state that social workers in all fields of practice have clients whose lives have been touched by HIV/AIDS. It is therefore the responsibility and obligation of a social worker to ensure that a section of his/her role includes education and training in this field. According to Jackson (2002:307-308) HIV/AIDS results in more families who become poor because of the death of the breadwinner. In the case of HIV positive women, it means that she is left without an income while being in a process of

mourning which creates immense financial strain on extended families. To address all these problems, social workers need to be trained in the field of HIV/AIDS to ensure that they will be able to meet these demands.

Due to the high number of infected women it is important for social workers to have the knowledge to address and assist HIV positive women's psychosocial stressors in a therapeutic group and not only on an individual basis. Van Dyk (2000:186) stressed this by stating that the need for counselling patients and relatives will soon exceed the capacity of all trained counsellors in Sub-Saharan Africa. Addressing the psychosocial stressors of HIV positive women who share a common denominator (their HIV status) in a group setting, saves time and also lessens the feeling of isolation for these women (Davies, 1975:33-34; Du Preez, 1981:53; Heap, 1977:3-10).

Johnson (2000:3) states that, apart from having the skills and knowledge, the single most important requirement of a social worker dealing with HIV positive women, is to have compassion with their struggle to live beyond the constraints of this disease and to help HIV positive women to focus on life beyond infection and not to waste energy on the constraints of the disease.

Grodeck (2003:126-129) motivates this, stating that what kept him sane for 15 years after being diagnosed as HIV positive, is the fact that he talked to other people in a structured and therapeutic environment. He also joined a support group of HIV positive people, which he describes as a life saver. At first he felt awkward about sharing his feelings with people he did not know, but he became more comfortable as he got to know them better. He felt less alone because often people in this support group described exactly what he was going through. They sometimes offered solutions he hadn't thought of. His anxieties and fears were also eased after joining this group.

In this chapter the following will be covered: definition of social group work, advantages as well as disadvantages of social group work, components of an effective group, comparisons of effective and ineffective groups, the elements of the group process and planning a group for HIV positive people that can also be applied to HIV positive women.

3.2 DEFINITION OF SOCIAL GROUP WORK

The Social Work Dictionary (1999:449) defines social group work as "an orientation and method of social work intervention where small numbers of people with the same or common problems meet on a regular basis and partake in specific activities to reach certain goals and objectives". The goals of social group work differ from group psychotherapy in this regard that it does not necessarily only treat or address emotional problems. Social group work also can be used for education, development of social and manual skills, changing value orientations, and changing or diverting anti-social behaviour. This is achieved through but not limited to therapeutic discussions.

Based on this definition a support group can be explained as a planned series of meetings that are structured. These meetings occur between people who share a common problem. These people encourage one another, share, give advice, share relevant information and support each other emotionally.

A social worker, or the members themselves, can lead the group. The structures within a support group can vary considerably (*The Social Work Dictionary*, 1999:474).

Not every collection or group of people can be considered a group. *The Oxford English Dictionary* (1989) defines a group as "a number of people or things that are a unit, because of a shared relationship or common similarities". Note should be taken of the fact that apart from this definition, there exists a number of different definitions of "groups" according to Johnson and Johnson (1997:11).

Davies (1975:22) doubts if there will ever be consensus on the definition of a group, because a group can differ in its size, physical properties, the duration for which the group will exist, or the perspective from which the social worker operates. Davies (1975:22) defines a group as "...a gathering of three or more individual human beings who may not expect to go on meeting permanently, in which direct person to person exchanges (verbal and non verbal) between each individual are at least possible. Between and amongst these individuals are some common interests and or purposes, some sense of identity and some mutual acceptance of interdependence."

For Garvin (1981:3) social group work is a method that is used in social work to assist individuals to better their functioning as social beings. This is achieved through face-to-face

interactions in small groups. The aims of the members of the group is to either change their own behaviour, the behaviour of others or both. Social group work is a unique, exiting, dynamic way to help people make the necessary changes in their lives that they themselves wish to acquire.

Johnson and Johnson (1997:11) combined all these definitions in one. According to the two authors a small group may be defined as two or more individuals who:

- share common goals
- are interdependent
- share norms concerning matters of common interest
- participate in a system of interlocking roles
- influence each other
- find the group rewarding
- define themselves and are defined by others as belonging to a group

There is no consensus among social scientists about which of these characteristics should be present in a group for that group to be defined as a social work group. For the purpose of this thesis the above-mentioned definition of social group work will be accepted because it suits the framework of the research.

3.3 ADVANTAGES AND DISADVANTAGES OF SOCIAL GROUP WORK

There are advantages as well as disadvantages to social group work that are also applicable to group work with HIV positive women. Balgopal and Vassil (1983:92-94), Davies (1975:33-42), Du Preez (1981:52-54), Fatout (1992:4-5) and Heap (1977:25) discuss the advantages of group work very generally for the benefit of the social worker that wants to do group work for the first time.

3.3.1 Advantages of social group work

The first advantage is to be part of a group and to function in a group setting. Everyone first functions in a family, then in a school and then at work, and participates in leisure activities in

a group setting. One cannot escape from being part of a group, and being part of a group gives one feedback about one's personality as well as one's effect on other people, because other people act as mirrors reflecting who or what one is, and is becoming (Davies, 1975:33-34; Garvin, 1981:6). In an HIV positive women support group the member will have the important human experience and sense of belonging.

The second advantage of group work is that through group work perceptions and self-perceptions are changed (Davies, 1975:35-38). In a supportive group setting the client may look again at his/her problems in a different way and gain more clarity of perception, after sharing his/her problem with the group members. In an HIV positive support group the women might suffer from feelings of disgrace and shame. Their perceptions of themselves might be very distorted. The group members, who act like a mirror, can then help the member to change her perception of herself.

The third advantage of group work, according to Brandler and Roman (1999:2-3), Davies (1975:38-39), Fatout (1992:4-5) and Garvin (1981:158-159), is that through group work the sense of isolation is reduced. The social worker can change a client's behaviour and situation by reducing the client's sense of isolation. A support group for HIV positive women can help them become more aware of common areas they share. The gains of being part of a support group can be very practical, like arranging for regular and reliable baby sitters and exchange of children's clothes and well liked companions and playmates, which makes the reduction of isolation very real for the women. Garvin (1981:211-214) states that group members have many different feelings, which they must learn to handle. The sources of potential help increase automatically once the HIV positive woman joins the group. It must be stressed that that help is only potential, but in a caring, supportive setup each group member can become a possible resource for one another. In the group the HIV positive women may at different times need acceptance, reassurance, support and/or practical advice or material assistance. Or they may need control or direct confrontation about their characteristics and the impact on their fellow group members. The other HIV positive women and not the social worker, who might be a foreign authority figure to the group, can offer this kind of help.

The fourth advantage of group work is that in the group new ways of behaviour can be rehearsed (Davies, 1975:39-42; Fatout, 1992:61-67; Garvin, 1981:19-20). In the support group of HIV positive women, the women can get very real opportunities for giving as well as receiving help. Their roles can be reversed, from helpless victim to helpful, sympathetic and

supportive participant. Their roles can also be to give relevant information or to give material assistance.

The fifth and biggest advantage of group work is that it is time saving and cost effective, according to Van Dyk (2000:186). The statistics show that for every two women who are infected, only one man is infected. With the growing number of HIV positive women, the number of trained counsellors will be outnumbered by the number of HIV positive women (Van Dyk, 2000:186). By getting these women in a group and addressing their needs and psycho-social stressors, they will be able to help each other. By creating groups, a large number of clients can be helped and supported. This will also address issues of discrimination and stigma as well as other psychosocial stressors.

The advantages of group work as a social work method are proven to benefit participating group members immensely, but there are however some disadvantages which will now be discussed.

3.3.2 Disadvantages or limitations of group work

Davies (1975:54-56) as well as Shulman (1984:171-175) state that despite all the advantages and potential linked to group work as a method of social work, it is also very important to mention the drawbacks and limitations.

One of the first limitations of group work, according to Davies (1975:54-55) and Shulman (1984:173-174) is what is called the "fear of groups" where the group worker is scared to do group work because of a lack of knowledge and also because he/she is insecure. These concerns are understandable, for without the knowledge to execute group work, group work will not happen.

A second disadvantage is when social workers do not prefer to do group work because they are not comfortable doing it according to Davies (1975:54) and Shulman (1984:171). The agency can also be unsympathetic, indifferent or mildly tolerant towards the group worker which could cause his/her confidence and motivation to weaken and therefore almost guarantee failure or limited success.

A third disadvantage of group work as a method of social work is that the group members can become group focused because individuals as well as their welfare are being sacrificed to the

group. This may cause or lead to feelings of isolation for the individual group member – the extra loneliness that comes from being lonely in a crowd (Davies, 1975:55). Shulman (1984:171) states that group members might have difficulty in identifying their self-interest with that of the other group members, in attempting the complex task involved in creating a mutual aid system, and in overcoming the difficulties in communicating honestly.

A fourth disadvantage can be that being in a group, the group can confirm the labelled status (HIV positive) and make it very difficult for these women to establish themselves in ordinary situations (Davies, 1975:55). The group should provide a bridge or link to outside situations and equip these HIV positive women to handle or deal with difficult situations. The validation for group work should not be on how the clients feel about or perform within the group, but on how clients feel and perform outside the group.

The last disadvantage of group work is that the term "confidentiality" may need some reinterpretation for the group because the social worker's definition of what confidential material is, may differ from or may not be accepted by the clients or group members. Even when it has been agreed within the group that confidentiality will be respected and protected, violations may still occur, because the group members may not recognize privileged information when they hear it (Davies, 1975:55). The biggest reason that social workers fear that the group experience may damage rather than help clients is because the confidentiality principle cannot be forced on its members, so confidential information can be exploited, both inside and outside the group by the members.

3.4 COMPONENTS OF GROUP WORK

A successful group process are interlinked and inter-dependent and contain several components. Johnson and Johnson (1997:33) define components of an effective group by using the following diagram.



Figure 3.1 Components of an effective group, cooperation and competition
[Source: Johnson, D.W. & Johnson, T.T., 1989]

Johnson and Johnson (1997:33-35) as well as Klein (1972) describe the different components that group processes contain according to Figure 3.1.

A first component of the group process is the member's ability to understand the goals of the group as well as the commitment to achieve it. The members create clear goals that are relevant to their needs and engage in joint efforts to achieve this.

Positive interdependence exists when one perceives that one is linked with others in such a way that one cannot succeed unless they do (and vice versa) (Johnson & Johnson, 1989). Group members should know that they sink or swim together and that their efforts are required in order for the group to succeed.

A second component of a successful group process is dependent on the open communication of ideas and feelings amongst group members. Effective communication is two ways and is the basis of all group interactions amongst the members.

A third component of the group process is that participation should be active and the leadership should be distributed. All members participate and are listened to. Members also accept responsibility for meeting leadership needs as it arises. Another part of this component is the flexible use of decision-making procedures. There are many different ways decisions can be made in a group with consensus being the most effective one.

A fourth component of the group process is the encouragement and constructive management of conflicts. The more effective the group, the more frequent conflicts of interest will occur amongst members.

A fifth component of the group process is the equality of power and influence. Members will influence each other on the basis of expertise, ability and access to information and not on authority making power.

A sixth component of the group process is high group cohesion within the group. The participation of members as well as the equalisation of leadership will result in the increase of cohesiveness in the group.

The seventh component of the group process is high problem solving strategies amongst members. Members face their problems and resolve them in a constructive way.

An eight component of the group process is high interpersonal effectiveness amongst members. When conflicts of interest are resolved constructively this could increase the group's effectiveness.

For a successful group process it is necessary to understand and implement the different components.

3.5 COMPARISON OF EFFECTIVE AND INEFFECTIVE GROUPS

Based on the exploration of the components of the effective group Johnson and Johnson (1997:35) made the comparison of effective and ineffective groups and states that the goals of an effective group are well defined and the goals of the individual match the goals of the

group. With ineffective groups habits are being imposed on members with the emphasis of being competitive.

In effective groups the communication habits are open and two-way and ideas and feelings are being emphasized while with ineffective groups the communication is only one way, feelings are suppressed or ignored while only ideas are expressed.

In effective groups every group member participates in activities. Leadership roles are rotated, which means that every group member will have the opportunity to assume leadership responsibilities in the group. In ineffective groups leadership is delegated and rests upon authority. Goal achievement is high on the priority list and not all members participate equally in discussions or activities. High authority members also dominate the rest of the group.

In effective groups the member's ability to perform certain tasks and to gather information will determine power and influence. To make sure that the individual's needs and goals are being met and contracts are incorporated, power in the group is equal and shared. In an ineffective group the position of members depends on influence as well as power, which is present only in the authority positions. The members should be obedient to authority, which is the rule.

With effective groups different methods are used at different times to make decision-making effective. Consensus of the group is very important, for the group facilitator encourages important decisions and group discussion. With ineffective groups the highest authority always makes decisions and members are not involved, or involved in a limited capacity, and group discussions are minimal.

In effective groups controversy and conflict are experienced positively and members' involvement as well as the quality of decisions that are being discussed, is enhanced by conflict. Conflict that is solved also promotes the continuance of the group, resulting in a group that is in an excellent operational form. In ineffective groups controversy and conflict are ignored, denied, avoided or suppressed.

With effective groups the emphasis is on individuality. Group cohesion is promoted through trust, support, acceptance and affection. The interpersonal, group and inner group behaviours are stressed. With ineffective groups it is about functions that are performed by members.

Cohesion is non-existent or ignored and members are controlled by force. Members are forced to strictly conform to the ideas and opinions of the majority.

In effective groups adequate problem solving is a priority while with ineffective groups problem solving is not. In effective groups the members regularly evaluate the effectiveness of the group and how it can be improved. Development of members and whether goals were achieved, are all considered to be of importance. With ineffective groups the highest authority evaluates the effectiveness of the group and decide how goals can be accomplished or improved. Development of the members is ignored by the highest authority and is not seen as important. In effective groups the interpersonal effectiveness of members, self actualisation and innovation are being encouraged while with ineffective groups, organizationally-minded persons who desire order, stability and structure are encouraged.

When the group achieves their goals, maintain good relationships and adapt to changing conditions, it can be defined as an effective group. To achieve this, group members must commit themselves to the group, they must accurately communicate their feelings and ideas, they must provide leadership, influence other members in appropriate ways, be flexible during decision making as well as face their conflicts and seek constructive resolutions. To be able to eliminate ineffectiveness of groups and enhance effective group work, it is imperative to be aware of the different elements that compose group work.

3.6 ELEMENTS OF THE GROUP WORK PROCESS

To understand the internal dynamics of group work, one should have information regarding the different elements that are present in group work. Kanopka (1963) said that when group work originated it was for reasons of practicality, while authors like Garvin (1981), Johnson and Johnson (1997) and Shulman (1984) state that today group work is a part of good clinical treatment. Group services were motivated more by economics than by client needs because the clients outnumbered the available services. To provide services to many clients at the same time was simply less expensive than having individual sessions, hence the assumption that group work started for the wrong reasons and therefore has been unsuccessful. It is often assumed that group work can be done with any population at any time, without thinking about the structure of the group, its purpose, the needs of the member and other factors related to content, population and agency. These factors are very important to ensure the success of the group when planning to do group work.

Brandler and Roman (1999:114) use a model that was developed by Kurland (1978:1982) to assist social workers to plan for group work with HIV positive women. This model focuses on seven areas that are important for planning a group, namely needs assessment, identification of purpose, considerations regarding composition, establishment of structure, identification of key content, methodology in pre-group engagement and examination of agency content (Du Preez, 1981:132-152; Fatout, 1992:15-18; Klein, 1974:69; Shulman, 1984:177-194). The planning model Brandler and Roman (1999:126-133) used involves the development of a support group of people with AIDS within an agency serving gay men and offering concrete services to education, counselling and advocacy for people with AIDS and their significant others, and the general public. Although the model of Brandler and Roman (1999:126-133) is for HIV positive people in general, this model will be changed and adapted to suit HIV positive women because this research is about psychosocial stressors HIV positive women experience.

3.6.1 Planning a group for women with HIV/AIDS

The model that Brandler and Roman (1999:114) use for successful groups will now be applied to group work for women who are HIV positive or who have AIDS.

3.6.1.1 Needs assessment

According to Brandler and Roman (1999:127) the HIV positive person's idea of their needs can be assessed during the preview interview. It is also relevant for group work with women who are HIV positive. What they say during the early screening interview can assist the social workers. Here are some examples of perceptions for group work with women with AIDS.

"I don't want to feel that I'm bad, that I deserve this like my father says"

"I feel so frightened, so vulnerable. I need to talk and be with people who have this fighting"

"I need someone to hear how scared I am and not run from me"

"I don't want to be alone with this. I don't know what to do. I don't know where to go, what to expect"

The social worker can evaluate as well as determine the group members' needs and fears during the early screening interview.

It is important that the social worker should be aware of and support the needs indicated during the early screening interview of the clients. A support group will lessen the feelings of isolation and alienation as well as the reality of being HIV positive. This negative image and fear of discrimination and rejection (Sewpaul & Mahlalela, 1998:138) will push HIV positive women further away from getting support and isolate them even more. Roehlin (1982), as referred to by Brandler and Roman (1999:127) describes the term "commonality of culture" which means that a group that accepts other members has the ability to reinforce and develop a positive identification that can counteract the negative image HIV positive people have. Brandler and Roman (1999:127) state that the HIV positive person may experience a dramatic increase in his or her emotional needs as well as physical needs. At the same time they might experience a sharp decrease in independent functioning and the availability of support systems.

The social worker must be able to anticipate the needs HIV positive women have as well as recognise ways on which to address these needs when developing a group. Gambe and Getzel (1989) as in Brandel and Roman (1990:128) say that the support group can act as an alternate "healthy family" when the group is fully accepting loving and capable of helping the women with AIDS to solve problems in a way that can strengthen her sense of self worth. In a support group she is not alone, everybody feels and experiences the same feelings she is experiencing, they struggle with the same problem. In the support group she can get validation, be cared for and get assistance in all the different areas of importance.

Other factors that should be considered as part of a needs assessment in establishing a support group is the fact that HIV positive women are prematurely confronted with questions about the meaning of life. The HIV positive woman must explore any and all options that could enhance the quality of her remaining time and must face all her fears.

3.6.2 Purpose

It is very important to determine what the purpose of the support group should be. Garvin (1981:23) as well as Douglas (1993:9) explain how different approaches can influence the purpose of a group and also present a set of techniques with which to achieve the purpose of the group. This is presented in Table 3.1.

Table 3.1 Approaches and techniques for achievement of purpose of group

APPROACH	PURPOSE	TECHNIQUES, TASKS or ACTIVITIES
Gestalt therapy	To create awareness to "own" belief and feelings	By attention to body language, role or dreams, fantasies and attitude
Transactional analyses	To discover the affect of ego states	Games and scripts
Psycho analytic group therapy	To examine reaction to common ideas and emotions and therapist conflict between need and fear of consequences	Interpretation to engender conflict resolution
Tavistock approach	To disclose basic assumptions on which members are operating	Worker inactivity and refusal to assume leader role
Guided group interaction	To describe peer group social processes which determine behaviour	Development of problem terminology, reshaping group norm by confrontation and manipulation
Self help groups	To develop interpersonal support	Support, acceptance, enhancing self esteem by helping others
Psycho drama	To disclose the public aspects of behaviour	Confrontation in dramatic role playing of actual behaviour
Behaviour modification in groups	To define precise goal definition & measurement of progress	Application of the principle of conditioning
T - groups	To learn about "how to learn" re interpersonal behaviour	Here-and-now focus; feedback in reaction, attention to group process
Social change movement	To promote a social ideal	Empowerment and support
Encounter movement	To engender values of spontaneity, honesty and validity	Encouragement of direct emotional expression, physical exercise

The purpose of having a support group for HIV positive women is to reduce and deal with psychosocial stressors. The social worker will apply all the above-mentioned techniques and activities or tasks and will also follow different approaches when dealing with HIV positive women in a group. The reason is that the needs of the group members will differ. The social worker should therefore be versatile and adaptable as well as sensitive to these needs. The purpose of having a support group for HIV positive people according to Brandler and Roman (1999:128-129) will be to help members cope with a life-threatening illness and to maximise their current or present life experience. The following individual and group goals presented by Brandler and Roman (1999:129) can be used as guidelines for group work with HIV positive women:

- to provide a mutual support system to reverse the effects of isolation
- to help members to vent their feelings, as well as to identify these feelings

- to provide concrete services and practical support when emotional and physical needs increase
- to offset feelings of helplessness and worthlessness through being part of a mutual support system
- to create an atmosphere to face one's own mortality.

The group members can support each other by helping one another, giving advice and listening. The members can get perspective on feelings and achieve a sense of belonging through supporting one another. They can openly talk about death and discuss the provisions to be made for it. Every group member will contribute to the effectiveness of the support group.

3.6.3 Content

The next activity of the social worker is related to the content of the support group sessions with HIV positive women. Brandler and Roman (1999:129) state that the content of the group should reflect the needs as well as the purpose of the group members. With an HIV positive women support group, the group should be set up as a combination of supportive counselling and education in which psychosocial stressors like anger, fear, loss, grief, guilt, denial and disclosure, depression as well as suicidal behaviour can be addressed and dealt with. The educational aspects could include information about the latest medical and legal information, because HIV positive women could need information on anti-retroviral medication as well as drawing up a will. The counselling components would help members to explore, express and resolve emotional issues. The overall focus of the group should be on the here and now, and should enhance the quality of each member's present situation.

3.6.4 Composition

Another element of the group work process is the composition of the group. The size of the group, according to Garvin (1981:151), determines the amount of time a group member will receive. According to Klein (1972), the optimum size is determined in relation to the nature of interaction desired. The smaller the group the more it demands involvement and the greater is its potential for intimacy. With a small group, worker accessibility and the ability to modify goals is easier because flexibility is greater. Larger groups allow greater anonymity and the group member can hide, withdraw or get lost in the group. The larger the group the more

formal the structures become. Sub groups can also form. With a large group it becomes difficult for members to get to know one another, and it is also difficult for the social worker to get to know the members. It becomes more difficult to work effectively when the group is too small. The ideal figure for a group should be between five to seven members but it also requires that everyone attends regularly.

Based on the previous discussion it is clear that an HIV positive women's group should ideally include between eight and ten members in order for discussions to happen effectively and for the optimal exchange of ideas and information. This number of group members provides enough variety for active dialogue but is not too large or too small to hinder intimacy. It is important to have enough members to allow for absences when members are unable to attend due to illness.

According to Brandler and Roman (1999:130) in groups with HIV positive people and therefore also for HIV positive women, it is advisable to have two co-leaders to ensure the continuity and security of the meetings and to prevent cancellation of meetings because of unexpected absences or planned vacations for the social worker. The stability of the group is a very important factor for these women who experience their lives as unpredictable and out of control (Van Dyk, 2001:258). An additional benefit of co-leadership in a group of HIV positive women is that the worker has a partner to vent feelings with.

Sameness and differences between worker and group members regarding a common problem is also an issue because it can either create conflict or enhance cohesion in the group. Brandler and Roman (1999:130) recommend that two workers should be involved with the group as the facilitators to ensure the continuity necessitated for the group with at least one worker free from AIDS symptoms. However, Shulman (1984:337) addressed the problems that can develop between co-workers. These include disagreement on the basic approach to the group, subtle battles over control of the group sessions and disagreement during the group session over specific interventions. Workers often feel embarrassed to confront their co-workers outside of the session and believe or think that it is unprofessional to disagree during the session. It is very difficult for two beginner workers to work together because of their own anxieties. Mutual trust and sharing should be developing between co-workers.

In the pre-group interview the feelings of the members about the composition of the group can be addressed. The group of HIV positive women might also have certain wishes that the

worker should assess regarding what must be part of the group. The success of a mixed group, that is a group consisting of men and women, according to Brandler and Roman (1999:130), depends on the pre-screening process as well as the ability of the worker to select those potential members who have a high degree of commonalities like the ability and willingness to verbalise and to confront feelings, the after shock status and time since the initial trauma of diagnosis, the mental status, the capacity for exploration and problem solving, the ability to relate to others, physical condition and level of denial.

According to Brandler and Roman (1999:131) ethnic differences can be one of the elements of a mixed group and can enrich a group of HIV positive women if the socio-economic distinctions amongst members are too dramatically different and if the ability to express feelings and use the group is strong.

Another concern about the composition of the support group according to Brandler and Roman (1999:31) is the inclusion or exclusion of care partners and significant others. It is advisable to have a group for HIV positive women only and to have a separate group for these care-givers and significant others. The social worker should know and plan the content of the group with the members, otherwise the needs of the HIV positive members will be ignored and this will set the group up for failure.

3.6.5 Structure

Structure is another element of the group work process, according to Brandler and Roman (1999:118), Du Preez (1981:133), Balgopal and Vassil (1983:118) and Johnson and Johnson (1997:19). Structure includes arrangements such as time and place of meetings. The worker must determine when and how frequently the group must meet, the time the meeting will be, and also the number of sessions to be held.

The worker must be able to motivate this planning of the structure of the group and decide if the group will be open-ended, which means new members can join continually, or if the group will be closed which means that the initial group members will be part of the group till its termination or until the members quit. The worker must also evaluate the members' capacity for change and loss. According to Brandler and Roman (1999:131) a modified closed group is the most appropriate structure for an HIV positive people's group. It is thus also relevant for a group consisting of HIV positive women. This modified closed group allows for members to join the group in order to replace members who left. This structure also ensures that the group

will continue even though the membership will change. It is very important that both new and old members should sign a contract of confidentiality of the group and commitment to the group to prevent instability and unnecessary loss in a group that will face far too many losses in its lifetime.

It is advisable that the group meet once a week to ensure continuity and stability. The group might be the only stable thing in the life of an HIV positive woman. Too many sessions can cause members to be exhausted. The ideal is to meet in the early evening after work. Meals and snacks may be served to help supplement healthy diets but the food need not be a priority.

When members become home based, arrangements can be made to keep contact with them through the use of telephones using the speakerphone. Effective planning of the HIV positive women support group will maximise its effectiveness as well as opportunity for success. The process of pre-group planning is complicated and the worker should evaluate this process continually as the planning proceeds.

3.7 CONCLUSION

To belong to a support group can improve the quality of lives of HIV positive women and can act as a catalyst in assisting them to disclose their HIV status in order to get medical help that can prolong their lives. All the psychosocial stressors that HIV positive women experience can be addressed in the group sessions which can result in the venting of emotions, reducing stigma and breaking the silence.

Group work, with all its disadvantages and advantages, is still the most effective method of social work to be used when dealing with HIV positive women. Effective planning of the social group maximises the opportunities for its success. The social worker must understand needs and consider the composition and structure, content and purpose of the group and then present the complete package clearly and in an almost ready-made approach. The process of pre-group planning is a complicated struggle to balance multiple factors and reduce resistance amongst members.

The next chapter deals with the findings of empirical research conducted with HIV positive women who are part of a support group at the Walvis Bay Multi Purpose Centre. The psychosocial stressors they experienced and their experiences regarding the support group will be discussed and compared with the literature review done in the previous two chapters.

CHAPTER 4

A SITUATION ANALYSIS OF PSYCHO-SOCIAL STRESSORS OF WOMEN LIVING WITH HIV/AIDS AND THE EXECUTION OF GROUP WORK TO ASSIST IN THE EMOTIONAL NEEDS OF THESE WOMEN

4.1 INTRODUCTION

Social workers need guidelines to be able to support and assist their clients. With regard to HIV positive women, it is important for social workers to identify the needs of these women. It is even more important to identify the psychosocial stressors these women experience in order to assist them to cope more effectively with their everyday lives. The aim of this study is to present guidelines for social workers to address psychosocial stressors in a support group setting.

In order to achieve the aim of the study, one of the objectives was to describe the nature and impact of psychosocial stressors that HIV positive women are experiencing and the manner in which it can be dealt with.

The previous chapters provided relevant information about HIV/AIDS and the various psychosocial stressors and the way in which these can be addressed in a group setting. This chapter explains the results of the study that was undertaken with HIV positive women.

4.2 EMPIRICAL STUDY

The following section contains the findings of the empirical research undertaken.

4.2.1 Research method

For the purpose of this study, an exploratory design was used which, according to Wellman and Kruger (2001), is used to explore a relatively unfamiliar research area. An exploratory design is also used to study cases that do not fit into particular theories. A qualitative research method was applied (Manchall & Rossman, 1989:21-22). This method is a plan to systematically ask questions to get a better understanding of an issue. De Vos and Fouche (1998:7) agree with the abovementioned and state that in qualitative research questions and problems for research mostly come from real world observations, dilemmas and questions.

The emphasis is to discover answers to important questions, processes and relationships, and not to test them.

The universe of this study consists of HIV positive women who attended a support group. Purposive sampling was used: the first six HIV positive women who were able to participate were used for the study. The six interviews with the HIV positive women were recorded at the Multi Purpose Centre in Walvis Bay over a period of four days.

4.3 RESULTS OF THE INVESTIGATION

The interviews were transcribed and the data was analysed to identify relevant themes. The data that was gathered is presented and discussed in terms of the semi-structured interview questions.

4.3.1 Identifying information

Personal information was organised into four categories. These are now discussed.

4.3.1.1 *Age of respondents*

The age of the respondents is important because it gives an idea of the average age of HIV positive women. Table 4.1 illustrates the ages of the respondents.

Table 4.1: Age of respondents

AGE	f	%
Under 19	0	-
20-29	2	33
30-39	2	33
40-49	2	33
Over 50	0	-
Total	6	100

N = 6

According to UNAIDS international figures (2001:1) women are becoming infected at a significantly younger age, and 50% of them are younger than 25 years of age. The table above indicates that two (33%) of the respondents are between 20 and 29 years, while four (67%) of

the respondents are older than 29 years. These findings do not correspond with the statistics of UNAIDS.

The table above indicates that two (33%) respondents fall in the 20 to 29 year bracket, two (33%) respondents fall in the 30 to 39 year bracket, and two (33%) respondents fall in the 40 to 49 year bracket. These findings correspond with Abdool (1998:15) as well as Tallis (1998:6) who concluded that the HI virus is mostly spread through unsafe sexual practises between men and women and have severe effects on women because their reproductive roles cause them to be defenceless against HIV infection. All the women in these different age brackets are in their reproductive ages.

4.3.1.2 Marital status

The marital status of the respondents was investigated because it gives an indication of their personal relationships. Table 4.2 illustrates these findings.

Table 4.2 Marital status

MARITAL STATUS	F	%
Married	2	33
Divorced	1	17
Single	3	50
Total	6	100

N = 6

The table indicates that two (33%) of the respondents are married, one (17%) of the respondents is divorced, and three (50%) of the respondents are single. What is notable is that half of the respondents are single and almost half were married.

4.3.1.3 Number of children of respondents

Table 4.3 indicates the number of children of the respondents.

Table 4.3: Number of children

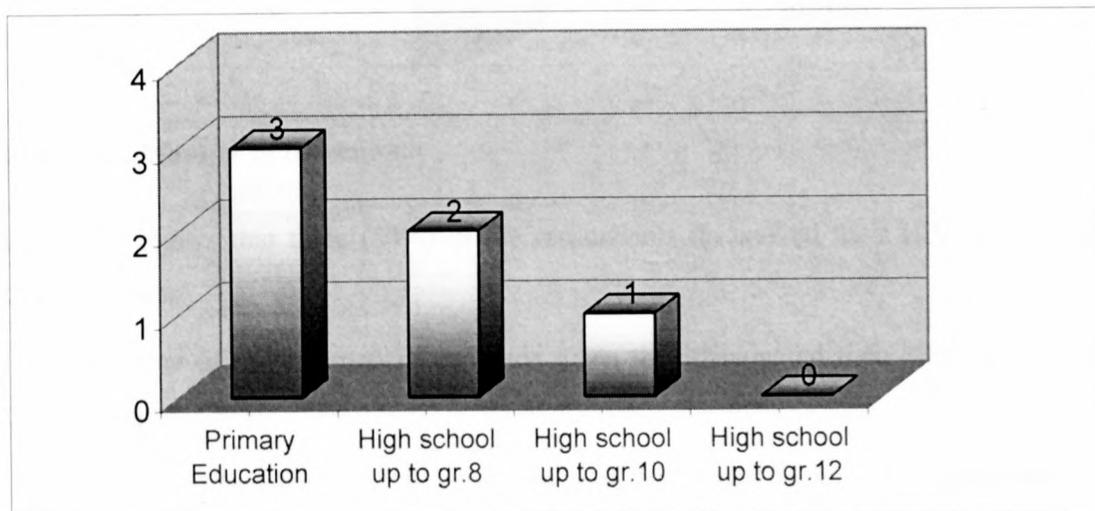
NUMBER of CHILDREN	F	%
0	1	17
1	1	17
2	1	17
3	1	17
4	2	33
More than 5	-	0
TOTAL	6	100

N = 6

From table 4.2 it can be seen that one (17%) of the respondents does not have any children, one (17%) respondent has only one child, one (17%) respondent has three children and two respondents (33%) have four children. None of the respondents has more than five children. It is noteworthy that three (50%) of the respondents are single and that five (83%) of the respondents have children.

4.3.1.4 Respondents' highest qualification

Figure 4.1 illustrates the highest qualification of respondents in this study.



N = 6

Figure 4.1 Highest qualification

From the figure above it can be seen that three (50%) of the respondents indicate their highest qualification as primary school, while two (33%) of the respondents completed Grade 8. Only one (17%) of the respondents completed Grade 10. None of the respondents completed Grade 12. This information gives an indication of the educational level of the respondents, which might have an effect on their understanding of the complexities and dynamics of HIV.

4.3.2 Background prior to the discovery of HIV positive status

For this study it is important to enquire how the respondents discovered their HIV positive status. These findings will be discussed below.

- **Manner of detection**

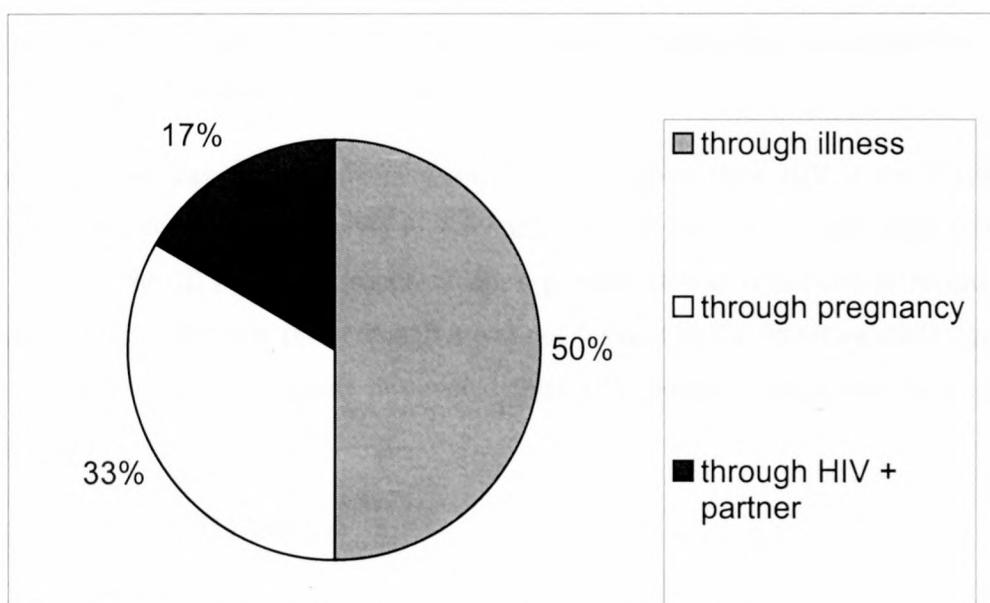


Figure 4.2 Manner of detection

Figure 4.2 shows that three (50%) of the respondents discovered their HIV positive status through illness.

Here are some of the comments they made when they discovered their HIV positive status through illness:

"I always had TB, even after treatment it always came back... The people said that after TB you also have Aids. So I decided to go for testing..."

"My body changed and I became ill. I also had a discharge and my leg was swollen. I was taken to the hospital for treatment and was tested."

"I got herpes and went to see the doctor. They tested me. "

These findings correspond with the manner in which Critzer (2002:1-2) found out about his HIV positive status. He also found out after he had the worst flu of his life and suspected something was wrong.

According to figure 4.2 two (33%) of the respondents discovered their HIV positive status through pregnancy. Here are their comments:

"I was pregnant with my third baby and then they tested me at the hospital."

"After the birth of my fourth child, I decided to be tested to see how I am."

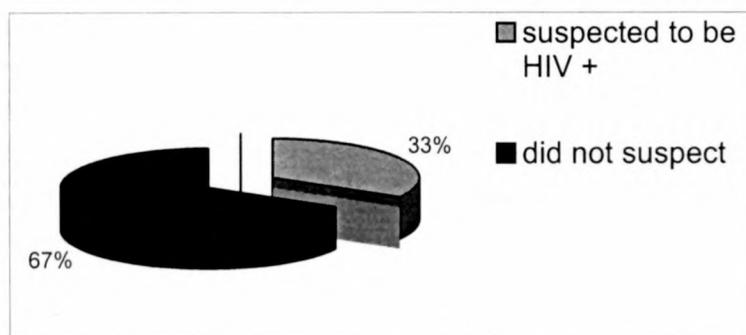
Figure 4.2 shows that only one (17%) of the respondents found out about her HIV positive status through her partner. Here is her comment:

"Me and my three cousins visited him in the hospital. We asked him what the doctor said was wrong with him. He didn't want to tell us. But we continued to ask him until he shouted - I have AIDS!"

There are different ways in which someone can find out about their HIV status. Firstly one can find out by testing after becoming ill. Secondly one can find out through pregnancy, and thirdly through the HIV positive status of one's partner. It was important to record these findings during the interview (even though it was not covered by the literature study), because the way in which the respondents discovered their HIV positive status was linked to the psychosocial stressors they experienced.

- **Suspected to be HIV positive**

During the interview the respondents were asked if they suspected that they were HIV positive. Figure 4.3 gives an illustration of their answers.



N = 6

Figure 4.3 Suspicion to be HIV positive

Figure 4.3 shows that two (33%) of the respondents did suspect that they were HIV positive, while four (67%) of the respondents did not suspect anything. Here are some of their remarks:

"I never suspected to be HIV positive because I was always faithful to my partner. Not once did I cheat on him."

"I never suspected to be HIV positive. I didn't believe it when they told me. I asked the sister maybe they had the wrong file."

"I suspected it because I had a dream that I was HIV positive but that I will be cured again."

The findings in figure 4.3 and the responses of the respondents correspond with the literature that suggests that people are mostly unaware that they are HIV positive, like Mtembu (1998:26) experienced it. According to the author she was shocked when she was diagnosed as HIV positive since she was from a religious family and had only one sexual partner and never slept around. Critzer (2002:1-2) experienced the same as he was also shocked and did not suspect that he might be HIV positive.

- **Counselling before HIV testing**

During the interview the respondents were asked if they were counselled before they were tested. Here are the findings:

Table 4.4: Counselling before HIV testing

COUNSELLED	%	%
Yes	5	83
No	1	17
Total	6	100

N = 6

Table 4.4 shows that five (83%) of the respondents were counselled before their HIV testing, while one (17%) was not counselled.

It was important to explore this question, even though this was not covered in the literature, because counselling before the test result is given can reinforce relevant information that can help the respondents to cope more effectively with the diagnosis.

4.3.3 Psychosocial stressors experienced after discovery of HIV positive status

One of the objectives of the study was to explore the nature of psychosocial stressors that HIV positive women experienced. The findings about each psychosocial stressor is discussed in the following subsections.

For this study it is important to explore the nine psychosocial stressors these HIV positive women experienced. All these psychosocial stressors are discussed one at a time, and the findings are evaluated below.

4.3.3.1 Anger

Van Dyk (2001:257) mentioned in her study that HIV/AIDS infected people often experience anger towards themselves and other. The following section contains the result from the interviews that were conducted by the social worker.

- **Anger experienced after being diagnosed as HIV positive**

Anger is one of the most common emotional stressors that HIV infected people experienced, but also the least expected, since HIV positive people do not expect to feel anger after their positive diagnosis (Van Dyk, 2001:297). Table 4.5 reflects this statement.

Table 4.5 Anger experienced after HIV positive results

ANGER	f	%
Yes	4	67
No	2	33
Total	6	100

N = 6

It is evident from table 4.5 above that the majority four (67%) of the respondents experienced anger after being diagnosed as HIV positive. Only two (33%) of the respondents did not

experience anger. As four (67%) of the respondents were angry after being diagnosed HIV positive, they directed their anger towards their boyfriend, partner or the father of their child and also towards their one-night stands.

Here are some of their comments made with regard to their anger after being diagnosed HIV positive:

"... he was my boyfriend for four years. I was angry because I believed him... He knew he was HIV positive. It was only after the birth of my fourth child that I went for testing and was told that I was infected. Then I found out that he has a lot of other girlfriends in other towns (he is a salesman). Then he left me for my cousin..."

"I was angry because I took him back. I knew he was HIV positive, he told me in the hospital. I felt sorry for him because he was the father of my children. I blamed myself..."

"I was sixteen when I ran away from home (Walvis Bay) to Johannesburg (Gauteng) in South Africa. I was very naughty in those days. My friend and me hitchhiked and got a lift with a truck. Half way to Johannesburg the truck driver forced me to have sex with him. It only happened once. In Johannesburg I got sick and went to the hospital. There I found out that I was HIV positive. I felt very angry, because he (the truck driver) did it to me. He knew he was infected. I hated him...."

"I was divorced and stayed single with only my children for five years. Then I met him and stayed with him for eight months. I loved him and he didn't look sick. I became sick very fast only eight months after I met him. I was tested for HIV/AIDS and was HIV positive. I was very angry because he knew. He also found out he was HIV positive and wanted to marry me. I was too angry and asked him to leave..."

"I was not angry just shocked."

"I never felt anger I just accepted my status."

The findings of the study and responses of the respondents correspond with Novaco (2002:188) who states that anger is a negatively toned emotion, which is subjectively experienced as an aroused state of antagonism, towards someone or something perceived to be the source of an aversive event. Grodeck (2003:9-10) agrees with this stating that HIV positive women can blame the people they care about, like a boyfriend, the father of their child and their partners.

- **Reason for anger**

The four (67%) respondents who felt anger explain their reason for anger as follows:

"I was angry because I went back to him and got myself infected. I blamed him and myself."

"I was angry because he infected me with the virus and started a relationship with my cousin. He just left me like this... He phoned my sister once and told her that if the baby is not HIV positive, then it is not his child... he never even apologised..."

"I was angry because I blamed myself. [If] I didn't ran away I would not have been infected ..."

"I was angry because he infected me. I couldn't forgive him. It helped that he apologised and wanted to marry me ..."

There are two themes that can be noticed here. Two (50%) of the four respondents blamed themselves or their partner, and that is the reason for their anger. One (17%) of the four respondents was angry because her partner did not apologise, while one of the four respondents could not forgive her partner even though he apologised. These findings correspond with Kaufman (1989:106) who states that self-blame or blame occurs when the HIV positive woman experiences mistakes, failure or mishaps. Kübler-Ross (1995:52) agrees with this, stating that anger when not expressed, leads to rage, revenge and hatred or unforgiveness.

- **Ways in which anger were expressed**

The four (67%) respondents had different ways in which they expressed their anger. Here are some of the ways:

"I had a lot of anger tantrums. I cried a lot. I swear at him a lot. I waited one year before I told him because I was afraid he will blame me for infecting him ..."

"I vent my anger on my older children ... They suffered a lot ... One day he came to look at the baby. I threw him with water. I think he left me because I blamed him too much ..."

"There was nobody to talk to in South Africa. I kept all my anger inside. Outside I was smiling but inside ... I cried a lot."

"I shouted at my children. I couldn't fight with him because he was quiet and submissive."

The first theme that could be drawn from the findings with regard to ways in which anger was expressed, is noted when two (50%) of the four (67%) respondents vented the anger on their children. These findings corresponds with Van Dyk (2001:257) who states that HIV/AIDS infected women often experience anger towards themselves and others, and that they direct this anger (on occasion) to the people who are the closest to them, like spouses and children.

Another theme from the findings regarding ways in which anger was expressed was crying and rage, which was experienced by two (33%) of the respondents. This corresponds with Novaco (2000:189) who states that anger is described as eruptive, destructive, unbridled, savage, venomous, burning and consuming. Kaufman (1989:21) resonates the same, stating that distress (the crying response) is part of the shame of being HIV positive.

- **Anger experienced still present day**

Four (67%) of the respondents are still experiencing anger even today, when reminded of their HIV positive status. The above-mentioned experiences of the respondents correspond with what Novaco (2002:188) who states that anger is a negatively toned emotion that is experienced as an aroused state of antagonism towards someone or something perceived to be

the source of an aversive event. The respondents' anger echo the same intensity of feeling as described by Antle *et al.* (2001:164): "I am mad all the time and take it out on my children, because I have no where else to put it."

4.3.3.2 *Fear*

According to Sunderland and Shelp (1987) as explained by Van Dyk (2001:296), fears experienced by HIV positive women can result in severe emotional strain. The following section contains the results gained from questions focusing on fear during the interviews that the researcher conducted.

- **Fear experienced after HIV positive diagnosis**

All six (100%) of the respondents indicated that they experienced fear after the diagnosis and initial shock. The following indicate how they experienced it:

"I was alone and very frightened. In the hospital next to me was a very sick woman who was suffering a lot ... she couldn't talk or anything, she was dying. I thought that I would end up like that".

"I was afraid to fetch my results at the hospital. I phoned them, but the nurse told me to come and see her. After she told me I was afraid that I would infect everybody. My brother-in-law does not like sick people ... I was afraid he will chase me away".

"I was afraid for my children ... that they will be left behind without care ..."

"I was afraid to die, for suffering great pain ..."

All six (100%) of the respondents are afraid to die. This corresponds with what Strydom (2002:145) states, viz. that fear of death is a realistic and frightening happening in the lives of AIDS sufferers. According to Van Dyk (2001:256) women grapple with the fear of dying and especially dying alone and in pain. All six (100%) respondents said that they became aware of this fear just after they were diagnosed as HIV positive.

- **Different fears**

The results of the kinds of fears experienced are reflected in table 4.6.

Table 4.6 Different fears experienced

FEAR OF	f	%
Isolation	3	50
Impairment	4	67
Uncertain future	0	0
Stigmatisation	5	83
Rejection of opposite sex	2	33
Death	6	100

N = 6

Table 4.6 shows that six (100%) of the respondents experienced fear of death, while two (33%) of the respondents fear rejection from the opposite sex. It is significant to note that both these respondents were single and in the age bracket of 20 to 29 years. Five (83%) of the respondents fear stigmatisation, while none (0%) of the respondents was afraid for the future. Four (67%) of the respondents were afraid of isolation or to be alone. Here follow some of their fears:

"I was afraid to die. I thought I would be dead in a few months".

"I was afraid to be alone. I did not want to be alone".

"I was afraid of what the people will say. When I left Namibia I was fat and now I am very thin".

"I didn't think of the future. I thought I would die any day".

The respondents experienced different kinds of fears like the fear of isolation, the fear to die and the fear of stigmatisation. These findings correspond with Van Dyk (2001:256) and Strydom (2002:143) and also with Sewpaul and Mahlalela (1999:38), who all state that women were concerned about how they would confront their own death. These women were afraid of dying alone, of stigmatisation and of discrimination.

When asked whether these fears are influencing the respondent's ability to take action, only one (17%) of the respondents answered yes. The rest (5 or 83%) of the respondents said that their HIV status didn't influence them. They were able to continue with their life. The respondent who could not continue with her life said:

"I stayed with my sister for one year, because I thought I would be dead in a few months. After the year, I returned to my house because of my four children".

Grodeck (2003:20), Panos Dossier (1990:50), Sewpaul and Mahlalela (1998:39), Strydom (2002:143) and Van Dyk (2001:296) all explain the respondent's experience, stating that when a woman is diagnosed as HIV positive, all hopes, stabilities, certainties, life plans and ambitions are threatened.

4.3.3.3 Loss

Sewpaul and Mahlalela (1998:36) explain that women find themselves in intolerable situations when they experience stress situations, which may lead to psychosocial deterioration like sudden and profound loss of mobility, or the fear of loss of bodily functions and then the actual pain of loss. The following section contains the results from the interviews conducted with HIV positive women.

- **Different kinds of loss experienced due to HIV positive status**

Figure 4.4 reflects the findings of the interviews conducted with the respondents. All six (100%) of the respondents indicated that they experienced losses due to their HIV positive status. There are different kinds of losses experienced by the respondents, like loss of children, physical wasting and loss of dignity, as indicated in figure 4.4.

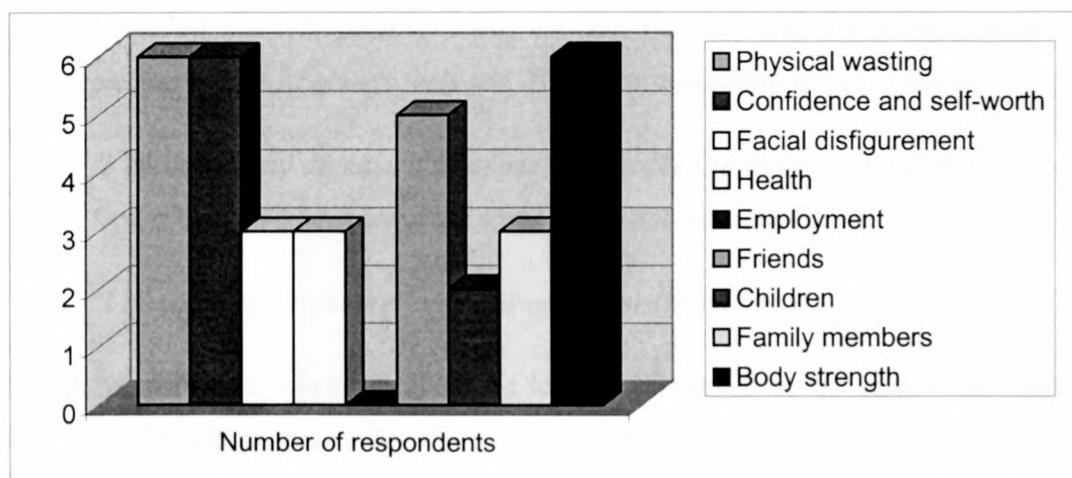


Figure 4.4 Kinds of loss

What is evident from Figure 4.4 is that all six (100%) of the respondents lost weight (physical wasting), which they are self-conscious about. Six (100%) of the respondents lost their confidence and self-worth, three (50%) of the respondent's faces are disfigured, while three (50%) of the respondent's health is giving way (they are becoming more sick every day with opportunistic illnesses). None (0%) of the respondents lost their jobs due to their HIV status. Five (83%) of the respondents have lost friendships because of the stigma attached to being HIV positive. Two (33%) of the respondents lost their babies due to mother-to-child infection. Three (50%) of the respondents lost family members, while all the respondents lost bodily strength. This part of the interview was very emotional and most of the respondents were crying. The following comments reflect their losses:

"I lost three children. I had to accept it that I cannot have children in my marriage. My husband blames me. I do not feel like a woman. I am pregnant again (4 months) and the baby is not his. I do not know if this baby will survive".

"I lost two aunts that was HIV positive. It was a big secret. Everybody knew they were HIV positive but nobody talked about it, because they were afraid of what people might say. I cried a lot..."

"I only lost friends. I am not sad, maybe because I hardened my heart. I never cried. My sister is also HIV positive. She cried when she told me, but I did not cry. I was disappointed too much in my life..."

"I lost four children. Only one child is alive. I do not know if I lost my babies because I was HIV positive. I was not tested at that time. My babies couldn't pick up weight...I always feels sad. This is not something you ever forget.

"I am losing my dignity. It's happening. People are looking down on me. My face is changing because of the sores... I do not have confidence anymore..."

"I lost a lot of weight and body strength. I used to be fat..."

The abovementioned comments about the losses experienced by the respondents correspond with what Katie Bias said as described in Panos Dossier (1990:46), that loss comes in many forms, not just in the form of death. Six (100%) of the respondents said that they lost confidence, which is in line with Van Dyk (2001:256), who states that loss of confidence and

self-worth is the biggest amongst HIV positive people, because of the rejection of people who once were their friends.

4.3.3.4 *Grief*

Kübler-Ross (1995:51) states that grief is a natural emotion and one of the greatest gifts given, to take care of the losses in life. Below are the findings of the interviews regarding grief:

- **Grief about losses**

In answer to the question whether the respondents grieve a lot about their losses, five (83%) of the respondents stated that they do. Here are some of their comments:

"I am HIV positive for nine years and still cry a lot, but only when I am alone because it upsets my children.

"I cry for the babies I lost ... it is not something you ever forgets. I cry because I feel I should have done more ..."

"I cry because he left me after he gave me the virus. I feel so angry at times. I was not someone that sleeps around ..."

"I am sad all the time ... I wish I did things differently ..."

The different themes regarding grief that the respondents have in common is that they cried a lot for losing their babies, they cried because they are HIV positive and they cried because their partner infected them. These findings correspond with the definition of grief according to the *Social Work Dictionary* (1999:200), which defines grief as "an intense and an acute sorrow resulting from loss". Kübler-Ross states that grief is an involuntary, complicated and psychological response after experiencing extreme trauma, in this case the diagnosis as HIV positive.

- **Stages of grief**

Table 4.7 reflects the stages of grief, as described by Kübler-Ross (1995), that the respondents experienced:

Table 4.7 Stages of grief

STAGES	f	%
Shock	6	100
Denial	4	67
Anger	4	67
Bargaining	1	17
Depression	6	100
Acceptance	3	50

N = 6

- **Shock**

All six respondents were shocked when they were confronted by their losses. Here are some responses:

"I overheard that the doctor and the nurse talked about me that I was HIV positive. I confronted the nurse and she told me. I shook and couldn't walk back to my bed."

"I was very shocked. I thought that God was punishing me for my sins. I cried a lot ..."

These findings in Table 4.7 regarding the first stage of grief, which is shock, corresponds with what Kübler-Ross states, namely that one experiences shock after one first hears about the loss.

- **Denial**

The second stage of grief is denial. Four (67%) of the respondents were in denial about their HIV positive status. Here are some of their comments:

"I did not believe it. I mean, I am not a loose woman with a lot of boyfriends. I was faithful. I asked the nurse if that was really my file".

"I couldn't believe it. I still cannot believe it, that is why I test myself regularly to see if my result changed".

The abovementioned findings corresponds with Kübler-Ross (1995) who states that denial is the second stage of grief which happens when one denies what is happening and for some time proceeds with life as if nothing happened.

- **Anger**

Four (67%) of the respondents were angry. Anger is the third stage of grief, and was experienced by four (67%) of the respondents. These findings concur with Kübler-Ross (1995) who states that anger is the third stage of grief experienced when one questions why this is happening, and then looking for someone or something to blame.

- **Bargaining**

One (17%) of the respondents went into bargaining, which is the fourth stage of grief according to Kübler-Ross (1995). This is her response: *"I made a bargain with the virus, that he will be my shadow for the rest of my life, and that I will respect it, but that it will not attack my body. I do not think about it always. I even sometimes forget I am HIV positive".*

According to Kübler-Ross (1995), bargaining is when someone starts making deals with oneself, someone else or God.

- **Depression**

The fifth stage of grief according to Kübler-Ross (1995) is depression. This was experienced by all six (100%) of the respondents. According to this Kübler-Ross (1995) depression occurs when the truth finally dawns and one is confronted with deep feelings of sadness and hopelessness, which corresponds with the findings of the respondents. All six (100%) of the respondents experienced different forms of depression, while only three (50%) of the respondents accept their HIV status today.

- **Acceptance**

The last stage of grief, according to Kübler-Ross (1995), experienced by the respondents was acceptance. Two (34%) of the respondents accepted their HIV positive status. Here is one of

their responses: *"I accept my result immediately after I heard. I was angry at him for infecting me, but what could I do?"*

According to Kübler-Ross (1995) acceptance happens when one finally accepts what is happening and decides to deal with the situation. This was the case with this respondent.

- **Ways of grief**

The following responses about grief were recorded from the respondents. Four (67%) of the respondents are afraid to grieve openly for reasons such as *"I do not want to upset the children"* and *"I do not want people to feel sorry for me"*. One respondent said *"I am ashamed of my HIV status and to cry openly would make people aware of this"*.

All six (100%) of the respondents are still sad today for being HIV positive.

4.3.3.5 Guilt

Sewpaul and Mahlalela (1998:37) state that HIV positive women experience guilt so severely and acutely, that they felt that people can see right through them. Below follows the findings of the interviews conducted by the researcher regarding guilt:

Table 4.8 illustrates guilt experienced by the respondents.

Table 4.8 Guilt experienced by respondents

GUILT	f	%
Self-blame	4	67
Shame	6	100
Remorse	6	100
Blames someone else	5	83

N = 6

Four (67%) of the respondents blame themselves for getting infected. This finding corresponds with Kaufman (1989:106) who states that self-blame occurs when the HIV positive women experience mistakes, failure or mishaps. All six (100%) respondents are ashamed to be HIV positive. Kaufman (1989:21) states that there are typically secondary

reactions to shame, like fear, distress (the crying response) and rage. Most of the respondents cried during the interview and experienced anger towards the person that infected them. All six (100%) of the respondents had remorse for past mistakes. Van Dyk (2001:302-303) states that remorse is included in feelings of shame and follows after blame or self-blame, which corresponds to what the respondents experienced. Five (83%) of the respondents blame their partners or someone else for infecting them. Two (33%) of the respondents felt guilty for infecting their children and losing them.

The challenge is to know when to let go of guilt. This is an ongoing struggle for HIV positive women who are confronted with their past every day.

4.3.3.6 *Denial and disclosure*

The finding about denial as one of the psychosocial stressors that HIV positive women experienced has already been captured when the stages of grief were discussed during this chapter. For the purpose of this section the focus will be on disclosure. The results of the interviews are discussed below.

Table 4.9 shows how long it took respondents to tell someone about their HIV positive status.

Table 4.9 Disclosure

TIME OF DISCLOSURE	f	%
One year	2	33
Two years	3	50
Three years	0	0
Four years	1	17
Longer than five years	-	-
TOTAL	6	100

N =6

The respondents disclosed their HIV positive status to their children, their husbands, their sisters and family members.

As shown in table 4.9, two (33%) of the respondents revealed their status to family or their children in less than a year; three (50%) of the respondents disclosed their status after two years; and one (17%) respondent revealed her status after four years. Grodeck (2003:2-8) states that many newly diagnosed HIV positive people block out this diagnosis completely for at least two years or more, which observation concurs with the respondents' behaviour.

The reasons why the respondents disclosed their status vary from telling their children to warn them about the dangers of unsafe sex to getting support from family members. Here follows some of the remarks of the respondents why they decided to disclose their HIV status:

"I only told my oldest daughter to warn her to be careful. She just kept quiet. Only when I became sick did she believe me".

"I waited more than a year before I told my husband, because I was afraid he will blame me for infecting him. We had a huge fight... today he supports me".

"I told my sister when [I] came from the hospital. We were alone at home. She told me that the family already knew I was HIV positive and that they will not reject me. It was a double shock. Everyone knew except me. They heard that my ex-boyfriend was sick with AIDS and assume that I will also have the virus".

One (17%) of the respondents had regrets for telling someone. Here follows her comment:

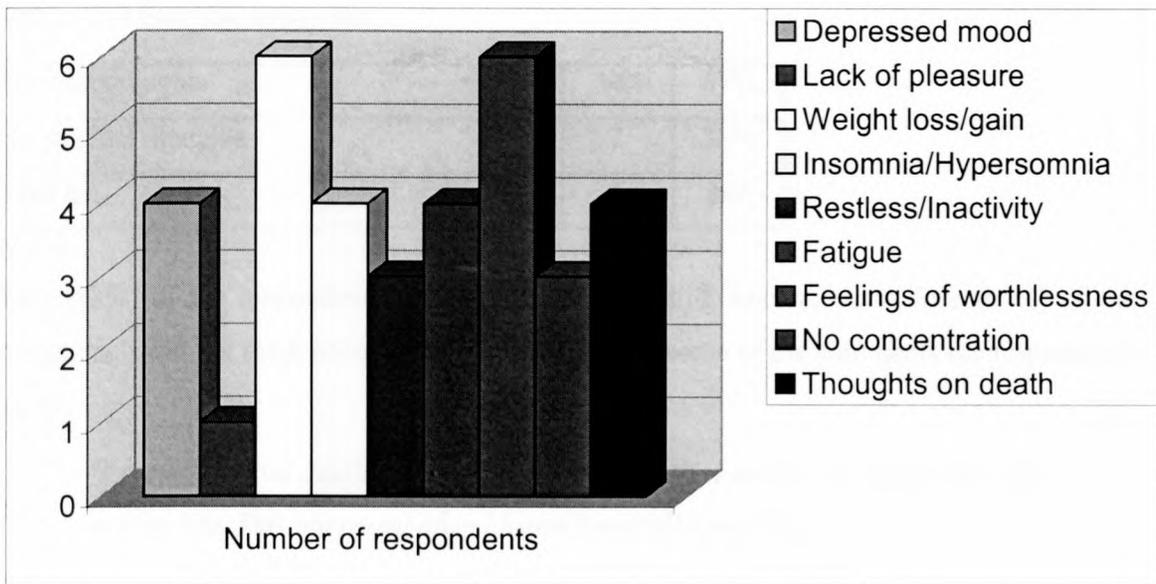
"I should not have told anyone. Now everybody knows and talks about me. I am very lonely. If I didn't tell anybody I could still get a boyfriend today."

Grodeck (2003:2-8) says that research has shown that one out of every five people with HIV/AIDS has regrets after telling people about their positive status. This is reflected in the abovementioned findings of the respondents.

4.3.3.7 Depression

Grodeck (2003:20) states that it is very difficult to recognize depression, because there are different diagnoses of depression just as there are different degrees of pain. Below are the results of the interviews conducted regarding depression.

Figure 4.5 captures the findings of the respondents that were depressed:



N = 6

Figure 4.5 Depression

According to figure 4.5 four (67%) of the respondents feel depressed throughout the day, one (17%) respondent does not have any interest in anything, five (83%) of the respondents lost weight, one (17%) of the respondents gained weight, four (67%) of the respondents cannot sleep or sleep too much, three (50%) of the respondents are inactive or restless, four (67%) of the respondents suffer from fatigue, all six (100%) of the respondents feel worthless while three (50%) of the respondents cannot concentrate and three (50%) of the respondents think about death often.

It is difficult to attribute these findings to depressive feelings because it could also be a result of the HI virus' influence on their bodies. Some of the respondents are on medication and the side effects of these medications can also result in similar symptoms. According to Barlow (1999:80) and Grodeck (2003:120), if five of the nine symptoms are present for at least two weeks, a person can be diagnosed as depressed. It therefore seems as if all six (100%) of the respondents are suffering from depression when one compares the results from the interview with the abovementioned literature (Barlow, 1999; Grodeck, 2003).

4.3.3.8 *Suicidal behaviour*

Sewpaul and Mahlalela state that 73% of the respondents in a study they conducted had suicidal thoughts especially after they were diagnosed as HIV positive. The findings regarding suicidal behaviour are indicated in table 4.10 and are discussed further below.

Table 4.10 Suicidal behaviour

Suicidal thoughts	4	67%
No suicidal thoughts	2	33%
TOTAL	6	100

N = 6

Two (33%) of the respondents thought about committing suicide, while four (67%) of the respondents did not think about suicide at all. Here are some of the comments the respondents made:

"I thought about death a lot and of killing myself. I wanted to drink pills and end my life. This happened after I heard I was HIV positive".

"I never thought about suicide. My children were too important".

"I never thought about ending my life. What will it help? What helped me a lot was that I could easily talk about my status".

"I drank a lot. My husband was blaming me and fighting with me. I wanted to hang myself, but I never attempt.

According to Linehan and Shearn (1998) there are environmental triggers for suicidal thoughts, which are applicable to HIV positive women like lack of support, negative events like financial difficulties, loss of family members and property and social conflict. The findings of four of the respondents who did not think about suicide might be attributed to the fact that all six (100%) of the respondents had social support and most had financial support.

None of the respondents attempted suicide, which is an indication that all of them wanted to live. The findings correspond with Grodeck (2003:17) who states that after he tried to commit suicide, all he could remember while having his stomach pump, was that he did not want to die.

- **Environmental triggers**

Linehan and Shearn (1998) have categorized certain environmental triggers that start suicidal behaviour, which can also be applied to HIV positive women. These triggers include lack of social support, negative events like financial difficulties, loss of close family members due to suicide, conflict, unemployment, lack of close friends and isolation. The result of the findings according to the interviews are presented in table 4.11.

Table 4.11 Environmental triggers

ENVIRONMENTAL TRIGGERS	f	%
Lack of social support	0	0
Financial difficulties	2	33
Loss of family members (commit suicide)	0	0
Conflict	3	50
Unemployment	5	83
Lack of close friends	0	0
Isolation	2	33

N = 6

All six (100%) of the respondents had social support. Only two (33%) of the respondents had financial difficulties. None of the respondents lost family members or close relatives due to suicide, while three (50%) of the respondents experienced conflict. Five (83%) of the respondents are unemployed, but are supported by family members or are getting disability grants. All six (100%) of the respondents are lonely for male company.

The most important thing is that all the respondents are having support from their families and were not rejected. None of them experience suicidal thoughts at present. The suicidal thoughts they had were just after they were diagnosed as HIV positive. This correspond with Van Dyk (2001:278) who states that suicide thoughts and acts happen around the time when a person finds out about his/her HIV positive status and again at the last stage of the disease.

4.3.3.9 Anxiety

Öhman (2000:226) states that anxiety is closely related to fear, and is often imagined. Here follows the results of the interview conducted regarding anxiety.

Table 4.12 Anxiety

ANXIETY	f	%
Do you feel anxious?	4	67
Are you afraid of dying	2	33
TOTAL	6	100

N = 6

Four (67%) of the respondents felt anxious, while two (33%) of the respondents were afraid to die. One respondent felt anxious because of the pain and suffering that she will be experiencing, while another felt anxious to leave her children behind. These findings correspond with Barlow and Durant (1999) who state that aspects of anxiety include conscious awareness of powerlessness to do anything about the disease or situation. These are some feelings the respondents experienced.

"I feel anxious. I fear the pain and suffering that lies ahead. I cry whenever I get sick, because I am afraid for the pain. I am not afraid to die ..."

"Yes I feel anxious. In the beginning I thought I would die soon. Now I feel anxious because what will happen to my children? I do not want to die soon ..."

"I am not anxious. I accepted the Lord in my life one and a half years ago. I am not afraid to die ..."

The majority of the respondents experienced anxiety, which is in line with Van Dyk (2001:302) who states that people who have a life-threatening disease like HIV/AIDS often experience anxiety as well as feelings of helplessness.

4.3.4 Information regarding the support group

Due to the high number of infected women it is important for social workers to have the knowledge to address and assist HIV positive women's psychosocial stressors in a therapeutic group and not only on an individual basis. Van Dyk (2000:186) agrees with this, stating that the need for counselling people and relatives will soon exceed the capacity of all trained counsellors in Sub-Saharan Africa. By addressing the psychosocial stressors in a group of HIV positive women who share as a common denomination their HIV status saves time and also lessens the feeling of isolation most of these women experience (Davies, 1975:33-34; Heap, 1977:3-10; Du Preez, 1981:53). Below follows the findings of the ways in which the respondents experienced the support group they were involved in.

4.3.4.1 The respondents' experience of the support group

Below follow the questions that the respondents were asked during the interview regarding the support group they attended. Here are four of the six respondents' remarks:

Table 4.13 Experiences of support group

DEMOGRAPHICS	RESPONDENT 1	RESPONDENT 2	RESPONDENT 3	RESPONDENT 4
Date when support group was joined.	2001	2002	2004	2001
How did you find out about the group?	I was one of the founder members.	My friend told me about the support group.	One of the support group members told me. I decided to join.	The founder of the group visited me in the hospital and asks me to join.
Changes that occurred because of participation in the group?	I was less lonely. I am positive for nine years and only come out publicly when I joined the group.	I became stronger in the group. I used to cry a lot, and the group helped me to accept my HIV positive status.	It was good to see that there were others like me. I felt less lonely.	I joined the group as an affected member. The group assist me after I was tested.
Friends in the group?	I made some close friends in the group.	Yes. I have friends in the group. Not everybody is my friend.	I made some friends in the group.	Yes. But not everyone is my friend.
Do you discuss personal issues in the group?	Everybody is very open in the group. I can discuss anything in the group.	It is not difficult to discuss personal things in the group. Everybody is open.	It is not difficult.	I can discuss anything and everything in the group.
Were you lonely before you joined the group?	Yes, very much. I was glad and relieve to belong to a group that are the same as me.	I was very lonely. It took me a year to disclose my status to my family. The group helped me with the loneliness.	Yes, I am still lonely. I can't always come to a group meeting because I have to look after my grandchildren.	Not really. I like my own company and to read.
Do you feel accepted in the group?	Yes.	Yes, we are all the same with the same struggles.	Yes.	Yes.
Do you get support in the group?	I got a lot of support especially through income generating projects. The group members visit me when I'm sick.	Yes. When I have personal problems I can discuss it in the group and get direction.	Yes, although I cannot always attend the group.	Yes. When my husband was in hospital the group supported me.
Are your individual needs addressed in the group?	Yes, but sometimes they discuss things that do not interest me at all.	I am the youngest member. Sometimes the older members discuss things that don't interest me.	Sometimes the group members have discussions that do not interest me.	I feel neglected especially when it is about relationships.
Is there confidentiality in the group?	Not always. Sometimes you discuss things and some members that were not present will know about it	Yes, I think so.	I think so. One can never know.	I think the members gossip among them.
Do you receive medical and legal information in the group?	Yes. People from outside talked to us every now and then about medicines or testaments.	Yes	Not yet. But then I am not always at the group meetings	Yes.

When asked about the date the respondents joined the support group, two (33%) of the respondents stated that they joined in the year 2001, one (17%) of the respondents said that she joined the group in 2002 and one (17%) in 2004. This information is important, as it is indicative of the continuity of the support group. If the group did not meet the needs of the members they would not stay in the group for a long period of time.

With regard to the question how the respondents were informed about the existence of the support group, their answers varied from being informed by friends to existing members. Three (50%) of the respondents were told by friends or fellow members, while one (17%) of the respondents was a founder member.

These findings indicate that the support group is well known in the community and that the members of the group are not embarrassed to tell others about the group.

When asked about having friends in the group, all four (83%) respondents indicated that they have made friends in the group. This finding corresponds with Brandler and Roman (1999:2-3), Davies (1975:38-39), Garvin (1981:158-159) and Fatout (1992:4-5) who state that through group work the sense of isolation is reduced.

All four (83%) of the respondents answered in the affirmative when asked whether personal issues are being discussed in the group. Not one of them had a problem discussing intimate information with the fellow members. This serves as a testimony for the measure of trust and openness that exists in the group, and as an indication of its effectiveness. This corresponds with Johnson and Johnson (1997:33) who state that in effective groups the communication is always open and ideas and feelings are discussed openly.

On the question if the respondents experience loneliness before they joined the group, three (50%) of the respondents answered positively, while one (17%) of the respondents liked her own company. These findings correspond with Brandler and Roman (1999:2-3), Davies (1975:38-39), Garvin (1981:158-159) and Fatout (1992:4-5) who state that the sense of loneliness of members is reduced through a support group.

When questioned about acceptance in the group, four (83%) of the respondents answered that they were accepted in the group. This could be an indication of group cohesion, which is highlighted by Johnson and Johnson (1997:33), who state that when a group member feels accepted in the group, it enhances group cohesion.

Brandler and Roman (1999:2-3), Davies (1975:38-39), Garvin (1981:158-159) and Fatout (1992:4-5) agree with this, stating that the gains of being part of a support group can be very practical as group members become resources to one another. This can be seen in the findings when respondents were asked about support in the group. Four (83%) of the respondents indicated that they are getting support in the group.

On the question of whether their needs are being met, two (33%) of the respondents answered in the affirmative, while two (33%) of the respondents did not echo the same sentiment. This could indicate that the group might become group focused and the need of the individuals are being sacrificed to that of the group (Davies, 1975:55), or that the group is functioning in an effective way (Johnson & Johnson, 1997:33).

Three (50%) of the respondents agree that there is confidentiality in the group while one (17%) respondent indicates the opposite. These findings could be indicative of the trust and openness of the group that is referred to by Johnson and Johnson (1997:33).

When asked whether legal and medical information was received when they joined the support group, three (50%) of the respondents indicated that it was indeed the case, while one (17%) of the respondents who joined the group late in 2004 was not given the same information. This is in line with what Davies (1975:39-42), Garvin (1981:19-20) and Fatout (1992:64-67) state, namely that group members could be assisted to change from helpless victims to helpful and sympathetic participants. That can only be accomplished through the informing and educating of group members.

4.4 SUMMARY

The research findings in this chapter reflect the experiences of the respondents regarding the support group. By attending a support group the respondents were assisted to come to terms with their HIV positive status while isolation was eliminated amongst them. The support group also serves as a platform for the respondents to vent their pent-up emotions and feelings openly and in an accepting atmosphere.

The information obtained will be able to give social workers and other professionals insight into assessing and supporting HIV positive women in a group.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The aim of this study is to provide an explanation of psychosocial stressors of HIV positive women and their experiences of their involvement in a support group. The first objective required a description of the nature and impact of psychosocial stressors. The second objective required an explanation how social workers can execute group work with HIV positive women to address the psychosocial stressors. This was done by means of a literature study and an empirical study. Conclusions are now drawn which can be used to inform social workers about ways in which to deal with the psychosocial stressors HIV positive women experience.

5.2 CONCLUSIONS

In terms of the findings the following conclusions can be drawn:

5.2.1 Identifying information

The respondents consist of six HIV positive women living in Walvis Bay. The ages of the respondents varied from twenty to forty-nine. Two of the respondents were married; one respondent was divorced, while three respondents were single. Five of the respondents had children and one respondent was childless. The number of children the respondents had varied from one child to four children. Three of the respondents finished primary school and two of the respondents finished schooling up to grade eight, while only one respondent finished grade ten.

At the time of the interview only one of the respondents was employed, which happened to be the one who completed grade eight. The rest of the respondents were dependent on financial support of family members as well as disability grants.

From the above it can be concluded that most of these women are adult mothers who are single or married and are employed or unemployed.

5.2.2 Background regarding discovering of HIV status

Three of the respondents found out that they were HIV positive after they were hospitalised, two of the respondents were informed of their HIV positive status when they became pregnant, while one of the respondents discovered her status when her husband was diagnosed as HIV positive. Two of the respondents suspected that they might be infected with the virus, while four of the respondents did not suspect that they were infected with the HIV virus. Five of the respondents were counselled before they received their HIV test result. Only one respondent was not counselled, although she did receive counselling later.

From the above it cannot be concluded that most HIV positive women do not suspect that they can be infected because they only have one partner. This is due to the fact that the sample consisted only of six women.

5.2.3 Psychosocial stressors

Conclusion regarding the nature of the psychosocial stressors the respondents experienced are now presented.

5.2.3.1 *Anger*

Four of the respondents experienced anger, while two of the respondents were not angry after they were told they were HIV positive. There were different reasons why the four respondents were angry, like their partner knew that he was HIV positive and did not say anything. Another reason was that the respondents blamed themselves for not taking better precautions. The four respondents had different ways in which they expressed their anger: some fought and quarrelled with their partners, and others took it out on their children. One respondent did not have anyone to talk to at that time and kept all the anger inside, which had an effect on her health. All four respondents are still experiencing anger today because they became infected.

It can be concluded that HIV positive women experience anger towards themselves as well as the person who infected them.

5.2.3.2 *Fear*

All six respondents experienced fear just after they were diagnosed as HIV positive. They all experienced different kinds of fear. Three of the respondents were afraid of isolation, four of

the respondents were afraid to lose their mobility, but none of the respondents were afraid for their uncertain future because they did not think they still had a future. Five of the respondents were afraid to be stigmatised. Two of the respondents were afraid to be rejected by the opposite sex and all six respondents were initially afraid to die. Despite the fear, five of the respondents felt that they could continue with their lives, while one respondent felt that she could not continue with her life because she was too afraid.

It can be concluded that HIV positive women experience different kinds of fear which range from fear of impairment and fear of isolation and stigmatisation to fear of rejection by the opposite sex and fear of death. Some of these fears are a result of ignorance.

5.2.3.3 Loss

All six respondents indicated that they experienced losses because of their HIV status. Loss comes in different forms as indicated in the literature study. One of these forms is losing too much weight because of HIV/AIDS. All the respondents lost weight, although some gained again, but not to their former shape. All the respondents lost their body strength as well as confidence and self-worth. The facial appearance of three respondents changed for the worst, while three respondents are struggling with their health. None of the respondents lost their jobs because they are HIV positive. Five of the respondents lost their friends. Two of the respondents lost their children and three of the respondents lost family members due to HIV/AIDS.

From the above results it can be concluded that HIV positive women experience losses such as physical wasting, facial disfigurement, confidence and self-worth, health, friends, children, family members and body strength. Loss is one of the more severe psychosocial stressors with which HIV positive women must deal every day.

5.2.3.4 Grief

When the interviews were conducted all the respondents cried during certain stages. Five respondents stated that they cry a lot, while one respondent said she never cried (although she started to cry during the interview). All of the respondents went through the different stages of grief, and some are still grieving. All six of the respondents were shocked when they were confronted with their different losses. Four of the respondents were in denial, and four were

angry. One respondent started bargaining. All six the respondents experienced depression, and three of the respondents accept their HIV positive status.

It can be concluded that HIV positive women experience ongoing grief, which is one of the psychosocial stressors that needs to be addressed by the social worker.

5.2.3.5 Guilt

Four of the respondents blame themselves for becoming HIV infected. All six the respondents are ashamed to be HIV positive. All six respondents have remorse and regrets for past decisions, and five of the respondents blame someone else for their predicament.

From this findings one can conclude that guilt is a psychosocial stressor that HIV positive women experience in one way or another.

5.2.3.6 Denial and disclosure

Four of the respondents were in denial. It took one year for two of the respondents to disclose their status, two years for three of the respondents to disclose their status and four years for one respondent to disclose her status.

It can therefore be concluded that the decision to disclose or not to disclose is a very difficult one for HIV positive women, and one that takes courage. Denial and disclosure are two psychosocial stressors that HIV positive women struggle with.

5.2.3.7 Depression

Four respondents experienced a depressed mood throughout the day. One respondent experienced a total lack of pleasure. All six respondents either lost weight or gained weight. Four respondents could not sleep or slept too much. Three respondents experienced either restlessness or inactivity, while four respondents suffered from fatigue. All six respondents had feelings of worthlessness, and three respondents could not concentrate. Four respondents were thinking of death.

As mentioned before, it is difficult to attribute these findings solely to depression as the side effects of some of the antiretroviral drugs cause similar symptoms. Some of the respondents were on treatment. Based on the findings of the study it is not possible to conclude that the respondents are suffering from depression.

5.2.3.8 *Suicidal behaviour*

Two of the respondents thought about suicide, while four of the respondents did not contemplate suicide at all. There were some environmental triggers present that could lead to suicide. Two of the respondents experienced financial difficulty. Three of the respondents experienced conflict situations, five of the respondents were unemployed and two of the respondents were alone meaning that they were not married or engaged in relationships. All of the respondents had social support in the form of family and close friends. None of the respondents lost family or close relatives to suicide attempts. The two respondents had suicide thoughts just after they were diagnosed as HIV positive, but they do not think about killing themselves anymore.

It can therefore be concluded that because none of the respondents actually attempted suicide, that HIV positive women want to live.

5.2.3.9 *Anxiety*

Four of the respondents felt anxious and two of the respondents were afraid to die. It can therefore be concluded that HIV positive women experience feelings of anxiety which the social worker can help them identify and deal with, as these psychosocial stressors can influence the respondent's life negatively.

5.2.4 *Experience of involvement in group work*

The date the respondents joined the support group varied from the year 2001 to 2004. The respondents were either informed by group members or friends about the existence of the support group. All the respondents felt that fellow members influenced their lives in a positive way. Most respondents made friends within the group. The respondents did not have difficulties to discuss sensitive issues with members of the group because of the openness between the group members. Most of the respondents were lonely before they joined the group. All the respondents felt accepted in the group. The respondents supported each other in various ways. Some of the respondents were unsure about the confidentiality amongst the members. Some members received vital information regarding medication and legal matters.

It can be concluded that the involvement of the respondents in a support group was mainly experienced as positive and supportive.

5.3 RECOMMENDATIONS

The following section contains recommendations based on the conclusions drawn from the research.

5.3.1 Anger

It is recommended that the social worker should be aware of anger because anger is one of the more severe psychosocial stressors that HIV positive woman experience. She should be able to identify it and have the knowledge to address it in a group setting.

5.3.2 Fear and loss

It is recommended that the social worker must be sensitive to this psychosocial stressor and have the knowledge to address it in the appropriate manner because all the respondents experienced fear after they been diagnosed as HIV positive and experienced some kind of loss.

5.3.3 Grief

It is recommended that the social worker should be familiar with the stages of grief because almost all of the respondents are still in the process of grieving. The social worker should also and be able to identify and assist the HIV positive woman with processing the grief.

5.3.4 Guilt

It is recommended that the social worker must be able to recognize guilt as part of the psychosocial stressors that HIV positive woman experience.

5.3.5 Denial and disclosure

It is recommended that the social worker should be aware of how denial and disclosure affect the HIV positive woman because it took two years or longer for the respondents to come to terms with their HIV positive status. The social worker should have the knowledge to lead and assist the HIV positive woman to disclose her HIV status.

5.3.6 Suicidal behaviour

It is recommended that social workers should be able to recognise suicidal behaviour and assist the HIV positive woman in this regard because this is a prominent psychosocial stressor that HIV positive women experience.

5.3.7 Anxiety

It is recommended that the social worker should be knowledgeable about anxiety and how it affects HIV positive woman in order to assist the HIV positive woman in an effective way because most of the respondents experienced anxiety.

5.3.8 The role of the social worker

It is recommended that social workers should assist HIV positive women not only on an individual basis but also especially in a group setting. It is recommended that the social worker should be able to identify the different psychosocial stressors in an HIV positive woman's life. Through the group process the social worker can provide HIV positive women with information that is relative to them, and lessen ignorance regarding HIV/AIDS. The social worker can assist the HIV positive women to develop positive attitudes towards their health as well as help them to develop their coping and problem-solving skills. Most importantly, by bringing these women together the social worker will enlarge their resources, as they will become resources to one another.

5.4 AREAS FOR FURTHER RESEARCH

The following areas need more research:

- Protection of women themselves when they are aware of their partner's infidelity
- The role of education in curbing the spread of HIV
- The contribution of poverty to HIV/AIDS
- The experience of HIV/AIDS as a trauma situation

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ANNEXURE A

INFORMED CONSENT BY RESPONDENT

The psychosocial stressors of women with HIV/AIDS involved in a support group (in Walvis Bay)

Declaration of the respondent

A. I confirm that:

1. I, the respondent was invited to take part in the above-mentioned research project, which is to be undertaken through the Department of Social Work of the University of Stellenbosch directed by R.F Feris a Masters student in social work.
2. It has been explained to me that:
 - 2.1 the goal of the study is to get a better understanding of the psychosocial stressors HIV/AIDS positive women experience
 - 2.2 the procedure will take place in a semi-structured interview that will take an hour to an hour and a half.
 - 2.3 there will be other respondents taking part in this study
3. I have been informed that the information that is gathered during the interview will be treated confidentially, but will be applied to the findings as contained in the Masters' thesis.
4. the above information has been given to me in the language
(.....) of my choice.

B. I hereby confirm that I participate voluntarily in the above-mentioned study.

Signed at on 2004

.....
Signature of respondent

.....
Signature of witness

ANNEXURE B

QUESTIONNAIRE FOR HIV POSITIVE WOMEN

Semi-structured interviews with ten HIV positive women at the Multi-purpose Centre in Walvis Bay were conducted. All the interviews were recorded and their permission was asked for this. HIV positive women were interviewed after the researcher had obtained their permission.

The empirical data will be organised according to the psychosocial stressors these women experience.

Section 1

Identifying particulars. The following particulars of respondents were discussed: age, marital status, number of children and highest qualification.

Section 2

Background to discussion of HIV positive status. The following questions were asked:

- How did you find out about your HIV positive status?
- Did you suspect that you were HIV positive?
- Did you expect to be diagnosed as HIV positive?
- Were you counselled before being tested?

Section 3

Psychosocial stressors experienced when HIV positive status was discovered.

3.1 Anger

- After being diagnosed as HIV positive, did you experience anger?
- Why were you angry?
- What made you angry?
- Did you expect to feel anger after being diagnosed as HIV positive?
- Towards whom did you express anger?
- How did you manage your anger?
- Are you still sometimes experiencing anger?

3.2 Fear

- After the HIV positive diagnosis, were you afraid?
- When did you become aware of this fear?

- What were you afraid of, isolation, impairment, uncertain future, stigmatisation, sexuality, and death?
- Were you rejected by spouse/partner because of HIV status?
- Are these fears influencing your ability to take action and do things?

3.3 Loss

- Did you experience any losses due to your HIV status?
- How did you feel about your losses?
- What did you lose?

Employment	health
Dignity	facial disfigurement
Physical wasting	loss of strength and body control
- Did you lose confidence and self worth?

3.4 Grief

- Do you grieve about your losses?
- Are you sad and when do you feel sad?
- How long were you feeling sad after the diagnosis?
- Did you experience these stages of grief:

Shock
Denial
Anger
Bargaining
Depression
Acceptance
- Are you afraid to grieve openly and why?
- Are you still sad after a period of time knowing your status?

3.5 Guilt

- Do you feel guilty because of your HIV status?
- Do you blame yourself for becoming HIV positive/
- Are you ashamed to be HIV positive?
- Do you have regrets for past mistakes?
- Are you lonely because you are ashamed of your HIV status?
- Do you feel guilty that you might have infected other people?

- Are your children Hiv positive because you transmitted the virus during pregnancy and childbirth?
- How do you feel about it?
- Did you cry a lot after discovering your HIV status?
- Are you still crying sometimes?
- Did you forgive yourself for becoming HIV positive?
- Do you blame yourself for not using a condom?
- Are you still ashamed today?

3.6 Denial and disclosure

- Could you believe your HIV positive status when you discovered it the first time?
- When did you accept your HIV positive status?
- How long was it before you told anyone?
- Did you tell anybody yet?
- Why did you decide to tell somebody?
- Do you have regrets for telling anyone about your status?
- Who are the persons you told?

3.7 Depression

- Did you experience depression?
- What were your symptoms?
- How did you feel during this time?
- Did you sleep well or not?
- Did you loose weight?
- Did you lose interest in daily activities?
- Were you tired throughout the day?
- How well did you concentrate?
- Did you think a lot about death during the day?

3.8 Suicidal behaviour

- Did you experience suicidal behaviour and thoughts?
- Were you supported by anyone during this time?
- Did you have financial difficulty?
- Did you lose any family member?

- Did you experience any conflicts with people?
- Did you attempt suicide?
- Do you know of family or close friends that committed suicide?
- Do you feel helpless in this situation?
- Did you tell anyone about your intention to commit suicide?

3.9 Anxiety

- Do you feel anxious?
- Are you afraid of dying?

Section 4

4.1 Group work

Questions will be asked regarding the support group the HIV positive women joined.

- When did you join the support group?
- How did you find out about the support group?
- Did you change because of the influence of the group?
- Did you get the support from the group?
- Do you have any friends in the group?
- Is it difficult to discuss personal things?
- Were you lonely before joining the support group?
- Do you feel accepted in the group?
- Did the support group members assist and support you in any way?
- Do you sometimes feel neglected in the group because your individual needs are not being discussed?
- Is there confidentiality in the group?
- Are your needs met in this group?
- Did you receive medical or legal information?