Does Stigma predict mental illness? A study of HIV/AIDS and Cancer patients in Gauteng Province, South Africa.

O Estigma prevê doença mental? Um estudo de pacientes com HIV/AIDS e Câncer na Província de Gauteng, África do Sul.

El estigma permite ver con antelación la enfermedad mental? Un estudio con enfermos de HIV/AIDS y Cáncer en la Provincia de Gauteng, Sudáfrica.

E.S. Idemudia[1]

School of Social Sciences, North West University (Mafikeng Campus), South Africa.

N.A. Matamela[2]

Voortrekker Hospital, Mopane

Abstract

Aim: This study is aimed at exploring whether HIV patients suffer more stigma than cancer patients and the consequences of this for mental health and to understand the influence of stigma on mental health. Method: Using a factorial design, data was collected from a conveniently sampled 100 patients diagnosed with cancer and HIV in clinics and hospitals around Gauteng Province. Majority of the participants were females 62 (62, 0%) while 38 (38.0%) were males. Age of respondents ranged from 20-73 years with a mean age of 44.4 years (SD = 11.6).

Results: Results revealed a significant main effect for enacted stigma F = (1.98), = 17.629, p < .001 and anxiety F = (1.98) = 5.750, p < .001. A post hoc Bonferroni also showed that HIV patients had a higher mean score of enacted stigma ($\overline{X}$ = 4.22) than cancer patients ($\overline{X}$ = 1.28) and also HIV patients reported more anxiety ($\overline{X}$ = 8.81) than cancer patients ($\overline{X}$ = 6.42). Enacted stigma significantly influenced GHQ Total, (F= (98) = 1.700, p < .05); Anxiety (F= (97) = 2.578, p < .004); and Depression (F= (97) = 3.390 p < .001). Perceived community stigma had one main effect for depression (F= (1.98) = 1.452, p < .05). There were no significant main effects for internal felt stigma and psychological dysfunctions. Conclusion: Recommendations included tailoring interventions to meet the cultural needs of patients. Other recommendation were made in accordance with the findings of the study

Keywords: Stigma/Mental Health/Mental Illness/Psychological Dysfunction/Psychopathology/HIV/AIDS/ Cancer/Gauteng Province.

Resumo

Objetivo: Este estudo tem como objetivo explorar se pacientes com HIV sofrem mais estigma do que pacientes com câncer e as conseqüências e entendimento do estigma na saúde mental. Método: Por meio do desenho fatorial, os dados foram coletados de uma amostra conveniente de 100 pacientes diagnosticados com câncer e HIV em clínicas e hospitais da Província de Gauteng. A maioria dos participantes era do sexo feminino 62 (62,0%) enquanto 38 (38,0%) eram do sexo masculino. A idade dos participantes variou de 20-73 anos com média de idade de 44.4 anos (DP 44,4). Resultado: Os resultados revelaram um efeito significativo para o estigma efetivado F = (1.98),= 17.629, p<.001 e ansiedade F = (1.98) = 5.750, p< .001. O Teste de Bonferroni (post-hoc) também mostrou que os pacientes com HIV apresentavam uma maior pontuação média de estigma efetivado ($\overline{X}$ = 4.22) do que os pacientes com câncer ($\overline{X}$ = 1.28) e pacientes com HIV também relataram mais ansiedade ($\overline{X}$ = 8.81) do que os pacientes com câncer ($\overline{X}$ =6.42). O estigma efetivado influenciou significativamente o Total de GHQ, (F=(98)=1.700,p< .05); Ansiedade (F= (97) = 2.578, p < .004); e Depressão (F= (1.98) = 1.452, p < .05). Não houve efeitos significativos principais para estigma sentido internamente e disfunções psicológicas.

Conclusão: As recomendações incluíram adaptar as intervenções para que atendam as necessidades culturais dos pacientes. Outras recomendações foram feitas de acordo com as conclusões do estudo.

Palavra-chave: Estigma/Mental Saúde/Mental Doença/Disfunção Psicológica/Psicopatologia/HIV/AIDS/Câncer/ Província de Gauteng.

Resumen

Objetivo: Este estudio tiene el objetivo de explorar si pacientes con HIV sufren más estigma do que pacientes con cáncer y las consecuencias y el entendimiento del estigma en la salud mental. Método: Por medio del diseño factorial, los datos han sido colectados de una muestra conveniente de 100 pacientes diagnosticados con cáncer e HIV en clínicas e hospitales de la Provincia de Gauteng. La mayoría de los participantes eran del sexo femenino 62 (62,0%) y 38 (38,0%) eran del sexo masculino. La edad de los participantes ha variado del 20 al 73 años con promedio de edad de 44.4 años (DP 44,4). Resultado: Los resultados han revelado un efecto significativo para el estigma efectivo F = (1.98),= 17.629, p<.001 y ansiedad F = (1.98) = 5.750, p< .001. El Test de Bonferroni (post-

hoc) también ha mostrado que los pacientes con HIV han presentado una puntuación promedia superior de estigma efectivo ($\overline{X}$ = 4.22) de lo que los pacientes con cáncer ($\overline{X}$ = 1.28) y pacientes con HIV también han relatado más ansiedad ($\overline{X}$ = 8.81) de lo que los pacientes con cáncer ($\overline{X}$ =*6.42*). El estigma efectivo ha influenciado significativamente el Total de GHQ, (F=(98)=1.700,p< .05); Ansiedad (F= (97) = 2.578, p < .004); y Depresión (F= (1.98) = 1.452, p < .05). No hubo efectos significativos principales para el estigma sentido internamente y disfunciones psicológicas.

Conclusão: Las recomendaciones han incluido adaptar las intervenciones para que atiendan las necesidades culturales de los pacientes. Otras recomendaciones han sido hechas en conformidad con las conclusiones del estudio.

*Palabras-claves***:** HIV, Cáncer, Estigma Mental, Salud Mental.

Introduction

Sub-Saharan Africa is more heavily affected by HIV and AIDS than any other region of the world. An estimated 22.4 million adults and children are living with HIV in the region: around two-thirds of the global total. In the absence of massively expanded prevention, treatment and care efforts, it is expected that the AIDS death toll in sub-Saharan Africa will rise. The World Health Organization (2007) reported that apart from HIV, cancer is a global burden that causes mortality across all nations. Cancer statistics in South Africa is very high (National Cancer Institute of Canada, 2004) and on the other hand, South Africa AIDS epidemic has been declared one of the worst in the world and shows no evidence of decline (Van Dyk, 2008, UNAIDS, 2006). Stigma has been found to negatively impart HIV treatment. Unfortunately, understanding how stigma affects psychological dysfunctions from a comparative perspective is hardly the focus in psychology and health research. Besides, our understanding of stigma is sometimes superfluous and Eurocentric. Understanding treatment for HIV or cancer should focus on the cultural knowledge of the people suffering the disease.

Disease or illness attribution is important in treatment and prevention programmes in Africa particularly with traumatic illnesses, (Idemudia, 2009). If an illness is negatively attributed as a causal factor for example as a result of being HIV positive due to a homosexual relationship or promiscuous heterosexual behaviour, such illness will be stigmatized. The logic in this argument closely follows the attribution theory which is significantly driven by emotions and cognition in which people tend to blame others for their troubles due to their uncontrolled behaviours or attitudes, (Heider, 1958, Jones, 1967 and Ross, 1977). The theory states that patients may be stigmatised when the disease they have is perceived as controllable, visible, and dangerous and such fears are associated with delay and avoidance of health seeking behaviour and the development of depression, anxiety, social isolation and many other psychological problems (Cobb & De Charbert, 2002). When people are held responsible for their illness or other conditions it will possibly invoke anger and resentment in the person attributing responsibility, which may consequently turn into social rejection and stigma (Breitkopf, 2004).

On the other hand, individuals who are not believed to be personally responsible for their condition may invoke a pity response from others (Breitkopf, 2004). This theory describes how people perceive others' behaviour and situation, which determines their reactions and attitudes toward those individuals (Myers & Spencer, 2004). The behaviour and condition of others can be attributed either to internal influences (i.e. motives and disposition) or to external influences (i.e. the situation). Unfortunately, people often commit the fundamental attribution error, which is the tendency for observers to underestimate situational influences and overestimate character influences, in their evaluation of others (Myers & Spencer, 2004). According to Breitkopf (2004), individuals who contracted HIV through no fault of theirs may invoke pity and sympathy.

In addition, there is a relationship between culture and illness attribution. Studies have shown that health and or illness are culturally defined and treated, since cultural meaning systems inform aspects of illness and some diseases are culturally specific, (Harkness & Keefer, 2000). Attribution of illness or diseases in Africa can be externally or internally caused, (Idemudia, 2009). The African therefore sees causation of physical and mental illness as components of problems that overlap each other attributed to internal and or external, and natural and unnatural causes (Idemudia, 2003, 2009). To an African, biology alone does not explain disease causation (Idemudia, 2004a, b, Madu and Idemudia, 1997). Disease causation can be personal, biological, stressful situational factors, social, environmental and spiritual, (Idemudia, 2004a, b, 2009). (For details on culture and health in Africa, see Idemudia, 2004 a, b, and 2009).

HIV/AIDS is linked with unprotected sexual encounter with an infected person, blood transfusion, and wound to infected blood contact, and mother to child transmission. Since HIV/AIDS have direct links with sexual intercourse, it is generally assumed that anybody who has contracted HIV or suffering from AIDS must have done so due to a promiscuous

living and therefore does not deserve any sympathy, hence a high level of stigma. In addition, van Dyk, (2008) corroborates the statement that methods of HIV infection also determine the extent of stigma experienced. Cancer on the other hand, can be attributed to genetic, stressful, spiritual factors. These factors are likely to be externally or internally explained depending on how relatives of the sufferer understand the aetiological factors of the cancer in question. The nature of attribution will affect the level of stigma attached to the illness. For example, if cancer is genetic and affects more than a family member causing several deaths to such family members, the community may so assume that such a family has 'death or killer disease' and this may discourage the community members from going to such a family to seek suitors or prospective men and women for future marriages. Again, if the cancer disease is attributed to punishment from the gods or ancestors, the sufferer will have no pity from the community members as s/he is perceived as being 'appropriately rewarded'.

According to Sadock and Sadock (2007), when persons learn that they have HIV, their psychological reactions include fear of: death, disfigurement, disability, abandonment, loss of independence, and disruption in relationships. They also worry about role functioning, and financial standings. Denial, anxiety, anger and guilt are also part of psychological reactions. Patients go through a number of emotions and psychological distress, before actually coming to terms with their diagnosis. The process is that patients are likely to be shamed as a result of stigmatization which in turn may lead to mental health problems. There is no doubt that the psychological reactions of Sadock and Sadock (2007) is also applicable to cancer patients.

Stigma is a singular Latin word (στίζω) meaning to 'brand,' 'mark' or 'disgrace'. Stigma has been defined by Goffman (1963) as an attribute or quality that significantly discredits an individual in the eyes of others, the person is seen as having an illness that is socially unacceptable, therefore he/she must be isolated or ostracized. People who are stigmatized do also experience shame defined as a negative emotion elicited when a person experiences failure in relation to personal or social standards, feels responsible for this failure, and believes that the failure reflects self-inadequacy and inappropriate behaviour (Lewis 1999).

Although the diagnosis of HIV and cancer can be associated with fear and stigma (Chapple, et al., 2004) research reports that cancer stigma does not invoke the attribution of blame that HIV or AIDS often carries. Crawford (1996) and Greene (2000), for example, found that the stigma associated with HIV/AIDS is higher than that associated with other stigmatized conditions, such as cancer. Similar findings were reported in a study that examined reactions to people with AIDS, serum hepatitis, Legionnaire's disease, and genital herpes (Triplet & Sugarman, 1987). Only people with HIV/AIDS were rated as being interactionally undesirable, yet patients with other diseases had relatively neutral ratings of interactional desirability. With 45 lung cancer patients, Chapple et al., (2004) in their study found that whether they smoked or not patients felt particularly stigmatized because the diseases is strongly associated with smoking and people die in an unpleasant way. Those who had stopped smoking years ago or had never smoked felt unjustly blamed for their illness. Some patients concealed their illness, which sometimes had serious consequences such as death which could perhaps been prevented.

Research has found that the experiences of stigma towards cancer and HIV/AIDS can perpetuate the epidemic in several ways: the fear of being stigmatized can lead to shame and non-disclosure of diagnosis, mental health may also be jeopardized due to the experience of physical violence, social isolation, and losing family support (Greene, 2000). Studies comparing HIV and cancer related shame and stigma have been few with Greene & Banerjee (2006) reporting that cancer stigma does not conjure the attribution of blame that HIV/AIDS often carries, although among published studies, this was the only study found.

Research studies have shown that stigma is compositely measured and reported. This is rather unfortunate because it can lead to data loss and interpretation. Stigma has three components: internal felt stigma (internalized guilt sanctions towards themselves), perceived community stigma (expectation of the community reaction towards having HIV or cancer), and enacted stigma (the actual experiences of stigma and discrimination, (Mdlalose, 2006). The objectives of this study are to understand whether if HIV and Cancer patients will experience stigma and psychological dysfunctions differently and to what extent stigma will influence mental health report. Based on the reviewed studies and claims, the researchers hypothesized that: (1) HIV patients will experience more stigmas than cancer patients and consequently report more psychological dysfunctions, and (2) that there will be a significant difference between types of stigma and symptom report.

Method

Design and sample: This study employed a factorial design using ANOVA. A total of 100 participants (50 HIV/AIDS patients and 50 cancer patients) participated in the study. Of the participants, 38 (38.0%) were males and the majority of them were females 62 (62, 0%). Age of respondents ranged from 20-73 with a mean age of 44.42 (SD = 11.65). The percentage of participants identifying with each

ethnic group is as follows: Pedi and Sotho (3) 3.3 %, Tsonga (7) 7.0%, Venda (38) 41.8%, Caucasian (37) 40.7 %, Zulu and Xhosa represented (1) 1.1% of the sample. Nine percent did not mention their ethnic background. The sample was largely Venda (41.8 %) and Caucasians (40.7%).

Instruments

Data was obtained with a questionnaire which consisted of 3 sections a, b and c. Section a assessed demographic variables such as gender, age, type of diagnosis, duration of diagnosis, and ethnicity. Section b contained the stigma scale (Westbrook and Bauman (1996) and section c consist of the general health questionnaire (GHQ-28) developed by Goldberg and Hillier (1979).

Stigma Scale (Westbrook and Bauman, 1996):

Stigmas were assessed using a validated and reliable scale developed by Westbrook and Bauman (1996). The scale was adapted for cancer patients. Similar items used to measure stigma among people with HIV/AIDS were used for cancer patients. The scale consisted of three subscales: internal felt stigma (feelings of shame or guilt and the oppressive fear of enacted stigma), perceived community stigma (thoughts about the community's reaction towards patients with cancer or HIV) and enacted stigma (the actual experience of shame and stigma). This questionnaire included a list of 49 questions and requires a patient to rate the degree to which each experience of stigma has occurred. A test-retest in two weeks showed a good reliability and internal consistency (Cronbach's alpha) for all the scales was over .88 in the present sample.

General Health Questionnaire (GHQ-28): Psychological functioning

Psychological functioning was measured using a General Health Questionnaire-28 (GHQ-28). The GHQ-28 (Goldberg, 1972, Goldberg and Hiller, 1979) was developed and used to measure mental health. The GHQ used here is a self-rated, 28-item version. Each question has four possible responses. Less than usual, no more than usual, not at all, and much more than usual. Some of the items are also reversed and so is the scoring. In this study, scoring was done in such a way that the higher the score, the poorer the psychological report of the patient. The questionnaire is divided into four subscales namely: subscale A (A1-A7) measuring somatic symptoms, subscale B (B1 - B7) measuring anxiety and insomnia, subscale C (C1 - C7) measuring social dysfunction and subscale D (D1 - D7) measuring severe depression.

A test retest in two weeks for this study demonstrated good reliability (0.90). The GHQ-28 is a widely used instrument and validated for African cultures. Gbolagunte, (1991) carried out a pilot study with 20 normal people, to establish the reliability and validity of the GHQ. Test = retest (in weeks) technique was used. The Pearson product moment correlation was also used to test for consistency. The result showed a positive and relatively high reliability yielding 0.71. Several studies (e.g. Gureje & Obikoya, 1990, Aderibigbe & Gureje, 1992) have been carried out in Ibadan, Oyo State of Nigeria to establish the validity of the GHQ. For instance it has been validated against the psychiatric Assessment Schedule (P.A.S), the correlation of which was 10.88.

Procedures

After an IRB approval from the University of Limpopo ethics committee in 2007, HIV patients were recruited from the local AIDS service organizations in Gauteng area while cancer patients were also recruited from their support groups or homes around Gauteng Province. All participants were given informed consent in their various organizations. Participation in the study was not coerced and was without monetary gains. Patients in their terminal stages were excluded from the study.

Participants were given questionnaires to answer. With those who reported inability to understand the questionnaire, one of the researchers took time to explain the questionnaire in simple grade 4 English. Interviews in public places were discouraged because of sensitivity and confidentiality issues, as well as the potential for disruptive background noise. Data for HIV/AIDS patients were collected between April and July, 2008 and between January 2008 and January 2009 for cancer patients. All data were collected from participants after they were informed about the study and agreed to participate. No identifiable markers were collected and all data were collected in privacy of the patient and no names were required on the questionnaires. The participants were told they had rights to withdraw should they choose to do so.

Results

Two hypotheses were tested with ANOVA. Hypothesis one which reported that HIV patients will experience more stigmas than cancer patients and consequently report more psychological dysfunctions, was tested using ANOVA. The results revealed a significant main effect for enacted stigma F = (1.98), = 17.629, $p < .001$ and anxiety F = (1.98) = 5.750, $p < .001$ (see table 1 below).

A post hoc Bonferroni was used to further compare the means to see the direction of the prediction. Results showed that there was a significant difference ($p < 0.001$) in the experience of enacted stigma among HIV and cancer patients. HIV patients had a higher mean score ($\overline{X}$ = 4.22) than cancer patients ($\overline{X}$ = 1.28). HIV patients also reported more anxiety ($\overline{X}$ = 8.81) than cancer patients ($\overline{X}$ = 6.42), (See table 2 below).

A perusal of table 2 shows that there were

Table 1
Summary of a one way analysis of variance of the experience of shame and stigma and psychological distress as determined by diagnosis.

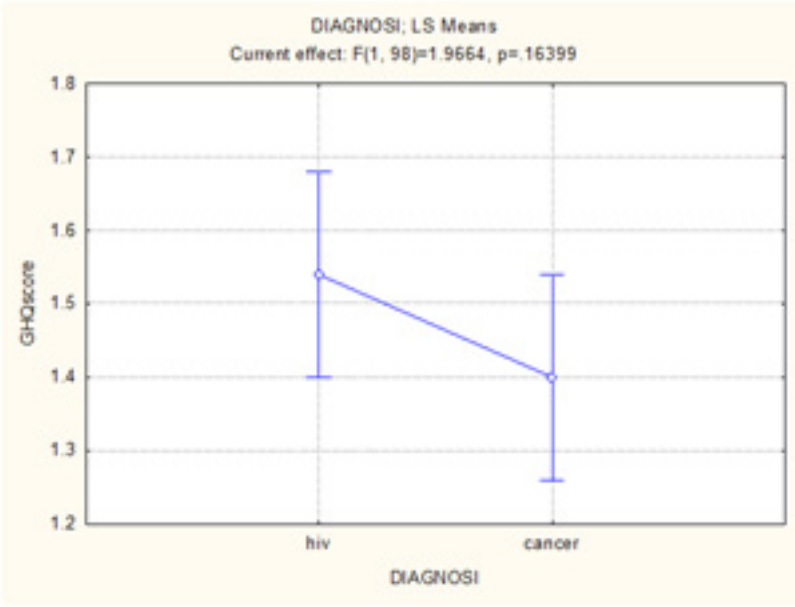
Diagnosis		*SS*	*DF*	$\overline{X}$	*F*	*P*
Internal felt stigma	Between Groups	43.560	1	43.560	.394	ns
	Within Groups	10844.200	98	110.655		
	Total	10887.760	99			
Perceived com stigma	Between Groups	195.948	1	195.948	1.208	ns
	Within Groups	15729.688	97	162.162		
	Total	15925.636	98			
Enacted stigma	Between Groups	214.561	1	214.561	17.629	.0001**
	Within Groups	1180.611	97	12.171		
	Total	1395.172	98			
Somatic	Between Groups	7.514	1	7.514	.449	ns
	Within Groups	1624.122	97	16.744		
	Total	1631.636	98			
Anxiety	Between Groups	142.109	1	142.109	5.750	.001*
	Within Groups	2397.527	97	24.717		
	Total	2539.636	98			
Social functioning	Between Groups	.978	1	.978	.088	ns
	Within Groups	1074.436	97	11.077		
	Total	1075.414	98			
Depression	Between Groups	20.264	1	20.264	1.239	ns
	Within Groups	1586.281	97	16.353		
	Total	1606.545	98			
Total GHQ	Between Groups	151.290	1	151.290	.966	ns
	Within Groups	15346.420	98	156.596		
	Total	15497.710	99			

**P < 0.001, *P< .001

Table 2
Mean scores in the experience of shame and stigma and psychological dysfunctions according to diagnosis.

	HIV Patients (N=48)	*Cancer Patients (N=50)*	
Variables	$\overline{X}$	$\overline{X}$	*p*
Internal felt stigma	22.66	23.98	
Perceived com. Stigma	29.30	28.12	
Enacted stigma	4. 22	1.28	p < .0001**
Somatic symptoms	5.44	6.00	
Anxiety	8.81	6.42	p < .001*
Social Functioning	5.93	5.74	
Depression	4.24	4.77	
Total GHQ	23.9	21.50	

Figure 1: A graphical illustration of the experience of psychological distress according to diagnosis.



significant differences for enacted stigma and anxiety with HIV patients scoring higher than cancer patients. Cancer patients had higher mean scores on internal felt stigma, somatic, depression but the difference did not reach acceptable levels of significance. In general, HIV patients have higher mean scores for total GHQ. Figures 1 and 2 below illustrate this further.

Hypothesis two predicted that there will be a significant difference between types of stigma and symptom report. However since enacted stigma was the main significant form of stigma, an ANOVA was computed for enacted stigma and psychological functioning. Results (table 3) showed significant main effects for GHQ Total, ($F= (98) = 1.700$, $p < .05$); Anxiety ($F= (97) = 2.578$, $p < .004$); and Depression ($F= (97) = 3.390$ $p < .001$). Perceived community stigma (table 4 below) had one main effect for depression ($F= (1.98) = 1.452$, $p < .05$). There were no significant main effects for internal felt stigma and psychological dysfunctions.

Discussion:

This study examined whether HIV patients will experience more stigmas than cancer patients and in addition whether type of stigma will influence symptom report. Two hypotheses were stated for the study: (1) HIV patients will experience more stigmas than cancer patients and consequently report more psychological dysfunctions, and (2) that there will be a significant difference between types of stigma and symptom report.

Results for hypothesis 1, showed that HIV patients suffered more of enacted stigma ($\overline{X}$ = 4.22 versus $\overline{X}$ = 1.28) and anxiety ($\overline{X}$ = 8.81 versus $\overline{X}$ = 6.42) than cancer patients, thereby partly supporting the stated hypothesis. The other forms of stigmas (internal felt and perceived community stigmas) and GHQ (somatic complaints, social functioning and depression) did not reach acceptable levels of significance although HIV patients have higher mean scores for total GHQ.

The results of the study conforms with Greene (2000) and Greene and Banerjee's (2006) study in which the authors reported that patients with HIV will tend to experience more stigma than cancer patients due to the association of HIV with behaviours that are already marginalized and that cancer stigma does not conjure the attribution of blame that HIV/AIDS often carries.

The results are also consistent with the assumptions of the attribution theory which states that individuals are held more responsibly for outcomes in situations where they are perceived to have control, and if the outcome is negative; the person receives more blame, less sympathy and pity (Cobb & de Charbert, 2002, Greene, 2000, Triplet & Sugarman, 1987).

Hypothesis two predicted that there will be a significant difference between types of stigma and symptom report. Results showed that enacted stigma was the only main significant variable with psychological dysfunctions. Enacted sigma significantly influenced Total GHQ, Anxiety and Depression. Perceived community stigma was significant with depression only. Internal felt stigma did not influence any mental health variable, thereby confirming partly the predicted hypothesis.

Figure 2: A graphical illustration of the experience of stigma according to diagnosis.

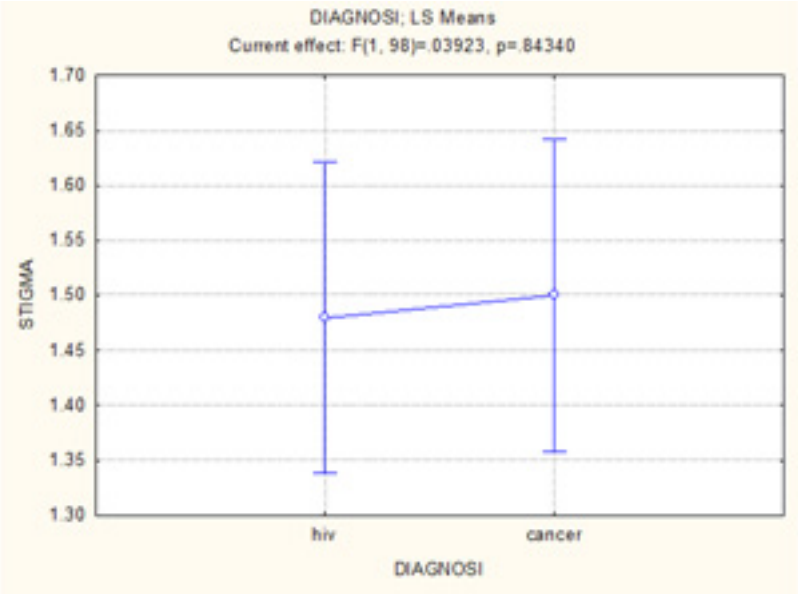


Table 3
Summary of the ANOVA of the influence of Enacted stigma on psychological functioning for the total sample.

	Enacted stigma	*Sum of Squares*	*DF*	$\overline{X}$	*F*	*P*
Total GHQ	Between Groups	3393.870	14	242.419	1.700	.05*
	Within Groups	11975.544	84	142.566		
	Total	15369.414	98			
Somatic	Between Groups	172.098	14	12.293	.699	ns
	Within Groups	1459.463	83	17.584		
	Total	1631.561	97			
Anxiety	Between Groups	769.168	14	54.941	2.578	.004**
	Within Groups	1768.506	83	21.307		
	Total	2537.673	97			
Social functioning	Between Groups	188.095	14	13.435	1.259	ns
	Within Groups	885.956	83	10.674		
	Total	1074.051	97			
Depression	Between Groups	559.646	14	39.975	3.390	.000**
	Within Groups	978.773	83	11.792		
	Total	1538.418	97			

**P < .001, *P < .01

Table 4
Summary of the ANOVA of the influence of perceived community stigma on psychological functioning for the total sample.

Perceived comm. stigma		*Sum of Squares*	*DF*	$\overline{X}$	*F*	*P*
Depression	Between Groups	699.516	34	20.574	1.452	.05*
	Within Groups	907.029	64	14.172		
	Total	1606.545	98			

*P < .05

The results are in agreement with past researches which also found that enacted stigma has been found to be associated with psychological dysfunctions such as depression and anxiety (Lindner 2006, Lee, Kochman & Sikkema, 2002), hopelessness, and suicidal thoughts (Van Dyk, 2001, Heckman, Kochman & Sikkema, 2002). The process and nature of enacted stigma includes overt negative behaviours such as labelling of people with stigmatized conditions, which can be a very painful experience leading to severe impact on mental health conditions of the patient.

Conclusion

In this study, the following conclusions are made:

- In general, HIV/AIDS patients were found to experience more stigmas than cancer patients
- Enacted stigma is found to be more significant than other forms of stigmas
- Anxiety is a significant psychopathology suffered by stigmatized HIV patients.
- Perceived community stigma has a significant effect on depression only
- Internal felt stigma had no effect on any psychological dysfunction.

Recommendations

Based on the above results and conclusions, it is suggested that community interventions for HIV and cancer patients be developed to reflect the cultural norms of the sufferers. This is very important because emotional expressions are culturally determined making Coulter (1979) to argue that socio-cultural dimensions are not mere contexts for emotional expression but are primary determinants of affect and integral to their very constitution. Fernando (1991) has argued that culture must play a large part in determining the way in which a particular event of emotional distress is conceptualised for example, whether it is seen as illness or to be cured or endured and or as a spiritual crisis to be resolved or experienced. Unfortunately the role of culture and health has been neglected in disease and health research and where it is applies, it is too Eurocentric in approach and intervention.

Patients' failure to disclose disease diagnoses stems from the stigma they experience and the government or NGOS should begin to put in place how to reduce stigma from the general population. If efforts are made in reducing or if possible eliminating stigma, people will be more likely to disclose and accept treatment.

The overt stigma displayed by communities to patients needs to be addressed. To change a community would require an open commitment from all sectors of the government, community leaders, and the media to support and care for people with HIV and cancer. More exposure and more talk in the community about how people with HIV and cancer can be supported may also contribute to a more realistic perception of community attitudes.

New intervention models should be developed and research in this direction be encouraged.

Limitations

The strengths of this study are that it investigated two groups of patients (HIV and cancer) using psychometrically reliable and valid measures, as well as the inclusion of men and women. However, some limitations remain: systematic sampling could not be used thereby limiting the generalizability of the findings of this study. Other personality factors can be investigated.

References

Aderibigbe, Y. A. & Gureje, O. (1992). The validity of the 28-item General Health Questionnaire in a Nigerian antenatal clinic. Social Psychiatry and Psychiatric Epidemiology 27: 280- 283.

Breitkopf, C. R. (2004).The theoretical basis of stigma as applied to genital herpes.Herpes, 11, 1-7.

Chapple, A. Ziebland, S., & McPherson, A. (2004). Stigma, shame and blame experienced by patients with lung cancer: a qualitative study. Department of Primary Health Care. University of Oxford: Oxford OX37LF.

Cobb, M. & de Charbert, J.T. (2002). HIV/AIDS and care provider attributions: who's to blame? AIDS Care, 14, 545-548. Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine, 38, 300-314.

Crawford, A. M. (1996). Stigma associated with AIDS: A meta analysis. Journal of Applied Social Psychology, 26, 398-416.

Coulter, J. (1979). The Social Construction of Mind: Studies in Ethnomethodology and Linguistic Philosophy. Macmillan, London

Fernando, S. (1991). Mental Health, Race and Culture. Macmillan/Mind Publications, London.

Gbolagunte, O.A. (1991): The impact of psychiatric illness on

the mental health of patient's spouses. Unpublished M.Sc. Thesis. Department of Psychology. University of Ibadan.

Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. Englewood Cliffs, NJ: Prentice Hall.

Goldberg, D.P. (1972). Manual of the GHQ-28. DJS Spools: Sussex. Retrieved on 29.09.07. from http://www.nfernelson.co.uk/health and psychology/resources.

Goldberg, D.P., & Hillier, V.F. (1979). A scaled version of the General Health Questionnaire. Psychol Med; 9:139-45.

Greene, K & Banerjee, S.C. (2006). Disease Related Stigma: Comparing Predictors of AIDS and Cancer Stigma. Journal of Homosexuality, 50 (4). The Harworth Press.

Greene, K. (2000). Disclosure of chronic illness varies by topic and target: The role of stigma and boundaries in willingness to disclose. In S. Petronio (Ed.), Balancing the secrets of private disclosures (pp. 123-136). Mahwah, NJ: Lawrence Erlbaum Associates.

Gureje, O & Obikoya, B. (1990). The GHQ 12 as a screening tool in primary care. Social Psychiatry and Psychiatric Epidemiology; 25: 276 - 280.

Harkness S and Keefer CH (2000) Contributions of cross-cultural psychology to research and interpretations in education and health. Journal of Cross-Cultural Psychology, 3, 92-109.

Heckman, T. G., Kochman, A., & Sikkema, K. J., (2002). Depressive symptoms in older adults living with HIV disease: Application of the chronic illness quality of life model. Journal of Mental Health and Aging, 8, 267-279.

Heider, F. (1958). The Psychology of Interpersonal Relations. New York: John Wiley & Sons.

Idemudia E.S., (2003) Tradotherapy and Psychotherapy in Africa: A Synthesis. In Sylvester Madu (Ed) Contributions to Psychotherapy in Africa. UNIN Press. The University of the North for the World Council for Psychotherapy, African Chapter, South Africa. Pp 32-44.

Idemudia, E.S. (2004a) Mental Health and Psychotherapy through the eyes of culture: Lessons for African Psychotherapy. In Arlt, H, & Idemudia E.S. (Eds) The Unifying Aspects of Cultures. Vienna Austria. Pp 230-232, 345. (Available Online/CD-ROM) http://www.inst.at/trans/15Nr/02_7/idemudia15.htm (41228 bytes).

Idemudia, E.S. (2004b) Culture, Psychosocial Disorders and Mental Health: An African Perspective. In Arlt, H, & Idemudia E.S. (Eds) The Unifying Aspects of Cultures. Vienna Austria. Pp 230-232, 345. (Available Online/CD-ROM) http://www.inst.at/trans/15Nr/02_7/idemudia/report15.htm (7393 bytes).

Idemudia E.S. (2005a). Psychotherapy. In Udegbe I.B., Balogun S.K., Osinowo H.O., and Sunmola A.M. (Eds) Psychology: Perspectives in Human Behaviour-Revised and Enlarged Edition: Department of Psychology, University of Ibadan, (Chapter 15) pp-331-354.ISBN: 978-039-140-1.

Idemudia, E.S. (2005b) A Cultural Approach to Mental health and Psychotherapy in Africa. In Madu, S. and Govenda, S. (Eds). Mental Health and Psychotherapy in Africa. Polokwane (Pietersburg), South Africa: The University of Limpopo Press for World Council for Psychotherapy African Chapter. Pp. 10-25.

Idemudia, E.S. (2009). Cultural dynamics of Trauma Expression and Psychotherapy: The African Perspectives (Chapter 5). In SN Madu (eds): Trauma and Psychotherapy in Africa (ISBN: 978-0-9814125-3-5) (Chapter 5). Pp. 43-50. University of Limpopo (Turfloop Campus), Press, South Africa for the World Council for Psychotherapy (African Chapter).

Jones, E. E. (1967). Fundamentals of Social Psychology. John Wiley and Sons Inc.

Lee, R. S., Kochman, A., & Sikkema, K. J., (2002). Internalized stigma among people living with HIV-AIDS. AIDS and Behaviour, 6, 309-319.

Lewis M. (1999) Shame and stigma. In: Gilbert P, Andrews B, eds. Shame: Interpersonal Behavior, Psychopathology

Lindner, G.K. (2006). HIV and psychological functioning among black South African women: An examination of psychosocial moderating variables. Georgia State University.

Madu SN and Idemudia ES (1997) Traditional healer's approach to the treatment of apoplexy (Hemiplegia) –Paralytic stroke (A case study in Nigeria). In SN Madu, PK Baguma and A Pritz (ed). African Traditional Healing (Psychotherapeutic Investigation). Facultas Universitaetsverlag Berggasse Vienna: Austria 5, A-1090. Pp. 175-181

Mdlalose B.N.N. (2006). Women's experiences of being HIV positive, the stigma related to HIV and disclosure of their status. Pretoria, South Africa: University of Pretoria.

Myers, D. G., & Spencer, S. J. (2004). Social Psychology (2nd ed). Toronto: McGraw-Hill Ryerson Limited. Retrieved from http://meducator.org./archive/20050214/03aids .html. on 30.09.2007.

National Cancer Institute of Canada, (2004). Statistics by Country for Cancer. Accessed on 1stApril 2008 from www.wd.co.za/cancer statistics.

Ross, L. (1977). The intuitive psychologist and his shortcomings: Distortions in the attribution process. In L. Berkowitz (Ed.), Advances in experimental social psychology. (10th ed). New York: Academic Press.

Sadock & Sadock (2007). Kaplan and Sadock Synopsis of Psychiatry: Behavioural Sciences/Clinical Psychiatry (10th ed) Philadelphia, USA: Lippincott Williams & Wilkins.

Triplet, R. G., & Sugarman, D. B. (1987). Reactions to AIDS victims: Ambiguity

UNAIDS (2006). July 2006. Report on the global HIV/AIDS epidemic: Geneva: Joint United Nations Programme on HIV/AIDS.

Van Dyk, A. (2001). Traditional African beliefs and customs: Implications for AIDS education and prevention in Africa. South African Journal of Psychology, 31 (2), 60-66.

Van Dyk., A., (2008). HIV/AIDS Care and Counselling: A multidisciplinary approach (4th ed). Pretoria, South Africa: Pearson Education.

Westbrook, L. E., & Bauman, L. J. (1996). Perceived stigma of HIV/AIDS scale. Bronx, New York: Albert Einstein College of Medicine.

World Health Organization (WHO), (2007). Data statistics. Retrieved on 30.07.2007 from www.who.co.za/cancer statistics.

Recebido: 29/12/2010
Última Revisão: 30/10/2010
Aceite Final: 25/02/2011

Sobre os autores:
E.S. Idemudia - Professor of Psychology, Department of Psychology, School of Social Sciences, North West University (Mafikeng Campus), South Africa.
N.A. Matamela - Clinical Psychologist, Psychology Unit, Voortrekker Hospital, Mopane, South Africa.