

The role of stigmas in mental health: A comparative study

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Background: HIV (Human immunodeficiency Virus), AIDS and cancer are feared terminal diseases. HIV sufferers are known to be stigmatized. The stigma surrounding cancer, unfortunately, is hardly the focus of psychological investigations, and hence this provoked the need to compare the stigma suffered by both groups, and how these have impacted on the psychological functioning of the disease sufferer.

Objectives: The study had two main objectives, firstly, to explore whether HIV patients suffer more stigma than cancer patients or not, and secondly, to understand the most common type of stigma and if stigma is associated with psychopathology. Psychopathology is measured with GHQ-28 which evaluates somatic complaints, anxiety, depression and social dysfunction.

Method: The study was a survey, and descriptive in nature, and anchored on two hypotheses: Firstly, that HIV patients will experience more stigmas than cancer patients and consequently report more psychological dysfunctions. Secondly that there will be a significant difference between types of stigma and the symptoms reported about them. Data were collected from a conveniently sampled group of 50 HIV positive patients and another 50 patients diagnosed with cancer, in two clinics and a hospital around the Gauteng Province. The majority of the participants were females, numbering 62 (62,0%), whilst 38 (38.0%) were males. The age of the respondents ranged from 20–73 years with a mean age of 44.4 years (s.d. = 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 ($X\text{-bar} = 4.22$) than cancer patients ($X\text{-bar} = 1.28$) and also HIV patients reported more anxiety ($X\text{-bar} = 8.81$) than cancer patients ($X\text{-bar} = 6.42$). Enacted stigma significantly influenced the GHQ Total ($F = (98) = 1.700, p < .05$); anxiety ($F = (97) = 2.578, p < .004$); and depression ($F = (97) = 3.390, p < .001$). The perceived community stigma had one main effect for depression ($F = (1.98) = 1.452, p < .05$). There were no significant main effects for internally felt stigma and psychological dysfunctions. Both hypotheses were partially supported.

Conclusion: Recommendations included tailoring interventions to meet the cultural needs of patients. Other recommendations were made in accordance with the findings of the study.

Introduction

The (Human Immunodeficiency Virus) and AIDS disease and cancer are feared terminal diseases because these diseases are life threatening and amongst the least understood in medical sciences. HIV is the only virus that is known to transcribe DNA (Deoxyribonucleic Acid) from an RNA (Ribonucleic acid) template (retrovirus) resulting in a person's immune system being attacked and destroyed. As a result, the body is unable to ward off foreign diseases which otherwise would have been prevented by the immune system, whilst cancer is a malignant disease, and once it metastasizes in the body the chances of recovering diminishes. A main difference between the two diseases is that HIV is an infection whilst cancer is not, and the modes of acquiring either of these diseases are different, and these differences may have ramifications for whether an illness will be stigmatized or not, because Africans perceive incurable diseases as abnormal and may attribute them to the handwork of witches and wizards, evil people or angry ancestors or gods (Idemudia 2004a:8). In Africa, attributing causality to ill health has ramifications for whether an illness will be stigmatized or not (Idemudia, 2009:46). HIV is known to be contagious and is associated with pre-existing social prejudices such as sexual promiscuity, homosexuality and drug use, and hence its stigma (Sallar, 2011:7, De Bruyn 1999:24, Alonzo & Reynolds 1995:4). In comparison, studies on cancer stigmas are scarce in Africa.

Problem statement

Statistics show that sub-Saharan Africa is more heavily affected by HIV and AIDS than any other region of the world with an estimated 22.4 million adults and children living with HIV in

the region: around two-thirds of the global total (UNAIDS 2006:34). Preventing HIV and AIDS has become a major problem because of the stigma that is attached to the illness (Sallar 2011:5). Piot (2006:10) has identified stigma as a priority area for the prevention of HIV and AIDS. In addition, stigma have been shown to impact psychological functioning negatively (Simbayi *et al.* 2007:12). The World Health Organization (2007:3) reported that apart from HIV, cancer is a global burden that causes mortality across all nations. Cancer statistics in South Africa are very high with about 33, 000 women dying of cervical cancer which translates into roughly 3, 000 per year and, in addition, approximately 7000 women develop this disease every year (Bomela & Stevens 2009:2; National Cancer Institute of Canada 2004:3). Therefore, this study compares cancer patients who have HIV or AIDS with the stigma study. This is a necessary study because researchers have identified an increase in morbidity and mortality resultant from cancer of the cervix which has been associated with the emergence of HIV and AIDS and, in addition, cervical cancer is now regarded as an AIDS defining illness (Bomela & Stevens 2009:2).

Stigma is a singular Latin word (*στίγμα*) meaning to 'brand,' 'mark' or 'disgrace'. Stigma has been defined by Goffman (1963:23) as an attribute or quality that significantly discredits an individual in the eyes of others, who is seen by them as having an illness that is socially unacceptable, therefore he or she must be isolated or ostracized. Unfortunately, understanding how stigma affects both groups and their psychological dysfunctions 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 from the disease.

In Africa, the criteria that determine whether or not an illness or disease is stigmatized depends on how aetiological factors are culturally determined and, as a result, illness attribution is important in treatment and prevention programmes (Idemudia 2009:47). Africans value morals. Therefore, if negative attributions (such as homosexuality which is almost a taboo in Africa or a promiscuous heterosexual relationship which is frowned upon) are linked to a disease, as in the case of HIV and AIDS, such illness is likely to be stigmatized (Idemudia 2009:44). 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 resulting from their uncontrolled behaviour or attitudes (Heider 1958:3; Jones 1967:10; Ross 1977:4). The theory states that patients may be stigmatised when the disease they suffer from 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 2002:9; Cobb 1976:3). 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 2004:4).

On the other hand, individuals who are not believed to be personally responsible for their condition may invoke a pity response from others (Breitkopf 2004:4). This theory describes how people perceive the behaviour and situation of others, which determines their reactions and attitudes toward those individuals (Myers & Spencer 2004:3). 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 2004:3). According to Breitkopf (2004:5), individuals who contracted HIV through no fault of their own 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, because cultural meaning systems inform aspects of illness, wherein some diseases are culturally specific (Harkness & Keefer 2000:10). Attributions about illnesses or diseases in Africa can be both externally and internally caused (Idemudia 2009:46). The African, therefore, sees causation of physical and mental illness as components of problems that overlap each other, that is attributed to internal and or external factors, and natural and unnatural causes (Idemudia 2003:38, 2009:45). To an African, biology alone does not explain disease causation (Idemudia 2004a:230, 2004b:233; Madu and Idemudia 1997:176). Disease causation can be personal, biological, stressful situational factors, social, environmental and spiritual (Idemudia 2004a:230, 2005:15, 2009:46). HIV and AIDS is linked with an unprotected sexual encounter with an infected person, blood transfusion, wound to infected blood contact, and mother to child transmission. Because HIV and AIDS has direct links with sexual intercourse, it is generally assumed that anybody who has contracted HIV or is suffering from AIDS must have become infected as a result of a promiscuous lifestyle, and therefore does not deserve any sympathy, hence a high level of stigma. In addition, Van Dyk (2008:12) corroborates the statement that methods of HIV infection also determine the extent of the stigma experienced. Cancer on the other hand, can be attributed to genetic, stressful, or 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 single family member, thus causing several deaths in a family, the community may so assume that such a family has a 'death or killer disease'. This may discourage members of the community from going to such a family to seek suitors or prospective men and women for future marriages. Additionally, if cancer is attributed to punishment from the gods or ancestors, the sufferer will receive no pity from the community members as she or he is perceived as being

'appropriately rewarded' or 'punished' (Idemudia 2009:46). According to Sadock and Sadock (2007:7) when persons learn that they have HIV, the process is that patients are likely to be shamed as a result of stigmatization which in turn may lead to mental health problems.

The questions raised by the authors include: Do HIV and cancer patients suffer stigmatization to the same extent or will HIV patients be more stigmatized than cancer patients? Is there a relationship between stigmatization and mental health? Unfortunately not much research has been carried out comparing both groups, which has, thus, created knowledge gaps in psychological research, hence the need to compare stigma for both groups.

Trends

Although the diagnosis of HIV and cancer can be associated with fear and stigma (Chapple *et al.*, 2004:5) research reports that the cancer stigma does not invoke the attribution of blame that HIV or AIDS often carries. Crawford (1996:399) and Greene (2000:124), for example, found that the stigma associated with HIV and 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 1987:2). Only people with HIV or AIDS were rated as being interactionally undesirable, yet patients with other diseases had relatively neutral ratings of interactional desirability. In their study of 45 lung cancer patients, Chapple *et al.* (2004:6) found that whether they smoked or not patients felt particularly stigmatized because the disease is strongly associated with smoking and death 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 have been prevented.

Research has found that the experiences of stigma by cancer, HIV or AIDS sufferers can perpetuate the epidemic in several ways: the fear of being stigmatized can lead to non-disclosure of diagnosis, mental health may also be jeopardized following the experience of physical violence, social isolation, and losing family support (Greene 2000:126). Studies comparing HIV and cancer related stigma are few, with Greene & Banerjee (2006:3) reporting that the cancer stigma does not conjure the attribution of blame that HIV and AIDS often carries, although amongst published studies, this was the only study found.

Research studies have shown that the stigma is compositely measured and reported. This is rather unfortunate because it can lead to data loss and, thus, a lack of interpretation. The stigma has three components: an internally felt stigma (internalized guilt sanctions towards oneself), a perceived community stigma (the expectation of the community reaction towards having HIV or cancer), and an enacted

stigma (the actual experiences of stigma and discrimination) (Mdlalose 2006:4).

The construction of the stigma whether or not it is internal or external is facilitated by social processes and institutions in a particular society for example, education (the marginalization of children, known to be born of parents who are HIV positive, from going to school), health systems (health staff not wanting to assist the HIV positive person), government policies and laws, the media, faith based organizations, the family, cultural organizations and others (USAID 2006:5).

According to Shisana and Simbayi (2002:10) and Shisana, Rehle, Simbayi *et al.* (2005:11), the externalized stigma is decreasing somewhat in South Africa, and is partly the result of the high visibility of the disease and proximity in the country. For example, Kalichman *et al.* (2003:445), in a Cape Town study, found that 43% of people surveyed in local townships and neighborhoods stated that people living with HIV and AIDS should not be allowed to work with children, and 41% felt that people with HIV or AIDS should expect to have restrictions placed on their freedom. As a result, the external stigma has been shown to bring about a strong culture of silence for fear of rejection and ostracism from close relatives and the larger community. In addition, the externalized stigma has been shown to also discourage disclosure of the HIV status which, in consequence, limits the resources and supports that are available to a person living with HIV.

In the United States of America, Lee, Kochman, and Sikkema (2002:309) found that 63% of HIV-positive persons sampled indicated that they were embarrassed by their HIV infection, and 74% stated that it is difficult for them to tell others that they are HIV positive.

Simbayi *et al.* (2007:1823) found that 40% of persons living with HIV or AIDS in Cape Town had experienced discrimination resulting from having HIV infection and one in five had lost a place to stay or a job because of their HIV status. In addition, many of the people living with HIV or AIDS (PLWHA) have indicated feeling dirty, ashamed, or guilty because of their HIV status. Kalichman *et al.* (2009:83) have also shown that the internalized AIDS stigma has the potential for adverse behavioural and emotional ramifications including: not seeking treatment and care services, engaging in unsafe sex practices, fostering a sense of isolation and emotional distress, and self-hatred. Lee, Kochman, and Sikkema (2002:309) also showed that internalized AIDS stigmas accounted for a significant and unique proportion of the variance in depression symptoms amongst people living with HIV or AIDS. These symptoms related to depression over and above demographic characteristics, the health status, symptoms of grief, and coping responses. Simbayi *et al.* (2007:1823) showed a relationship between the external stigma and health and treatment status, social support, substance use, and additionally the internalized stigma significantly predicted cognitive-affective depression.

Kalichman *et al.* (2009:88) also showed that internalized stigma was positively associated with depression in Swaziland, the US and South Africa. The objectives of the study are to explore whether or not HIV patients suffer more from this stigma than cancer patients, understand the type of stigma that affect patients more and the consequences of this for mental health. Based on the literature and theoretical understanding, the researchers hypothesized that: firstly, HIV patients will experience more stigmas than cancer patients and consequently report more psychological dysfunctions and, secondly, that there will be a significant difference between the types of stigma and the symptoms report about them.

Contribution to the field

The World Health Organization (2007:2) reported that apart from HIV, cancer is a global burden that causes mortality across all nations. The stigma related to HIV is a major barrier to curbing the HIV or AIDS pandemic worldwide because it drives the epidemic underground. The stigma is considered as one of the main reasons why people do not wish to know their HIV status, do not protect themselves and others from the virus, do not go for treatment, and do not care and support people living with HIV. It negatively affects all aspects of HIV prevention, diagnosis, treatment and care (Bond *et al.* 2002:347; Brown, Trujillo, & Macintyre 2001:5). In support of these findings, Chesney and Smith (1999:1162) and Eisenman, Cunningham, Zierler, Nakazono, and Shapiro (2003:125) reported that the fear of being stigmatized leads some people to avoid HIV testing, and amongst those who have been tested and are HIV-positive, the stigma constitutes a chronic source of stress that may contribute to coping difficulties, inadequate self-care, and difficulties with safer sex negotiation and condom use. Literature on cancer and stigma studies is scarce because little research previously compared HIV and cancer patients in relation to stigma. The few studies sourced for comparison were undertaken outside Africa. In addition, any attempt to explain the relationship between stigma and HIV theoretically, is Eurocentric. This study will benefit health professionals such as nurses, psychologists and social workers as it tries to compare the different stigmas between cancer and HIV patients, and theoretically the study tries to explain stigma from a cultural perspective. The findings of this study will help identify which group suffers more extensively from stigmatization and the consequences of this for mental health. The study will also help improve literature in the area of HIV and cancer and stigma research.

Research method and design

This study is descriptive and is in the form of a survey design involving one hundred (100) participants (50 HIV or AIDS patients and 50 cancer patients). All participants were conveniently sampled. Participants were recruited from two selected clinics, hospitals and residential homes in Johannesburg, Gauteng Province, South Africa. A total

of 120 questionnaires were given out but only 100 were satisfactorily completed, and twenty questionnaires were void, which was the consequence of being incomplete as a result of the patient's inability to continue research or the complete absence of the participant. Of the participants, 38 (38.0%) were males and the majority were females 62 (62, 0%). The age of the respondents ranged from 20–73 years with a mean age of 44.4 (s.d. = 11.6). The percentage of participants identified 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%, and 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%).

Materials

Data were 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 1996:2) and Section C consisted of the general health questionnaire (GHQ–28) developed by Goldberg and Hillier (1979:139).

Stigma Scale

Stigmas were assessed using a validated and reliable scale developed by Westbrook and Bauman (1996:2). The scale was adapted for cancer patients. Similar items used to measure the stigma amongst people with HIV or AIDS were used for cancer patients. The scale consisted of three subscales: the internally felt stigma (feelings of shame or guilt and the oppressive fear of enacted stigma), the perceived community stigma (thoughts about the community's reaction towards patients with cancer or HIV) and the enacted stigma (the actual experience of shame and stigma). This questionnaire included a list of 49 questions and required a patient to rate the degree to which each experience of stigma had occurred or was experienced. 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): Mental health

Psychological functioning was measured using a General Health Questionnaire–28 (GHQ–28) (Goldberg 1972:4, Goldberg and Hiller 1979:140). The GHQ used in this study 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 reversed and so is the scoring. In this study, scoring was taken 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.

Data collection methods

After an Institutional Review Board (IRB) approval from the University Ethics Committee in 2007, the managers of the homes and clinics were also consulted for study approval. After permissions were granted, patients were recruited after agreeing to participate. They were given informed consents. Participation in the study was not coerced and was without monetary gains. Patients in their terminal stages of illness were excluded from the study, as were those below 18 years of age. This was because of a problem associated with parental consent for children and young adults.

Participants were given questionnaires to answer. For those who could not comprehend these in the English language, 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 or AIDS patients were collected between April and July, 2008 and between December 2008 and April 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 with due privacy towards the patient and no names were required on the questionnaires. The participants were told they had the right to withdraw should they choose to do so.

Data Analyses

As a result of the nature of the variables, the study was anchored on two hypotheses comparing HIV and cancer patients based on the stigma of each and their consequences on mental health. As a result, we were interested in comparing group means across multi level variables and the direction of any observed difference. As a result, a series of one way analyses of variance was used to test the hypotheses. Where significant results were observed, a *post hoc* (Bonferroni) test was used to test the direction of the differences.

Results

Two hypotheses were tested with one-way Analysis of Variance (ANOVA). Hypothesis one, which stated that HIV patients will experience more stigmas than cancer patients and consequently report more mental health problems, was tested using ANOVA. The results revealed significant main effects for enacted stigma $F = (1.98), = 17.629, p < .001$ and anxiety $F = (1.98) = 5.750, p < .05$, thus partially supporting the hypothesis stated.

A *post hoc* Bonferroni was used to further compare the means to see the direction in the mean difference. Results showed that there was a significant difference ($p < 0.001$) in enacted stigma amongst HIV and cancer patients. HIV patients had a higher mean score ($X\text{-bar} = 4.22$) than cancer patients ($X\text{-bar} = 1.28$). HIV patients also reported more anxiety ($X\text{-bar} = 8.81$) than cancer patients ($X\text{-bar} = 6.42$). Internal,

perceived stigmas, somatic, social dysfunctions and depression of the GHQ did not reach acceptable levels of significance.

Hypothesis two predicted that there will be a significant difference between types of stigma and symptom report. However, because the enacted stigma was the main significant form of the stigma, an ANOVA was computed for the enacted stigma and psychological functioning. Results showed significant main effects for the 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 effect for internally felt stigma and psychological dysfunctions, which thus partially supporting the stated hypothesis.

Ethical considerations

After an ethical approval of the study by the University of Limpopo Ethics Committee (Turloop Campus), and the Department of Health, Gauteng Province, the participants were recruited. Participation was voluntary and not coerced. Patients who participated were informed of the nature of the study and if they agreed to participate they were then given a consent form. In the questionnaire used, no identifiable markers were collected such as names or addresses, telephone numbers and all data were collected with respect to the privacy of the patient. Patients were also told about their rights not to fill out the questionnaire should they choose to do so after they had started. The authors emphasized the importance of confidentiality of responses and patients were told to report any psychological side effect that may result from the study. The participants were told they had the right to withdraw from the study should they choose to do so.

Trustworthiness

A test-retest in two weeks for this study demonstrated good reliability (0.90). The GHQ-28 is a widely used instrument and is validated for African cultures. Gbolagunte (1991:23) carried out a pilot study with 20 normal people, to establish the reliability and validity of the GHQ. The 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 1990:277; Aderibigbe & Gureje 1992:280) 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.

Discussion

This study examined whether or not HIV patients will experience a stigma to a greater extent than cancer patients and in addition whether or not this type of stigma will influence the mental health symptom report. Two

hypotheses were stated for the study: firstly that HIV patients will experience more stigmas than cancer patients and consequently report more psychological dysfunctions and, secondly, that there will be a significant difference between types of stigma and symptom report. Results for hypothesis 1 showed that HIV patients suffered more from enacted stigma ($X\text{-bar} = 4.22$ versus $X\text{-bar} = 1.28$) and anxiety ($X\text{-bar} = 8.81$ versus $X\text{-bar} = 6.42$) than cancer patients, thereby partly supporting the stated hypothesis. The other forms of stigma (the internally 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 conform with Greene (2000:124) and Greene and Banerjee's (2006:4) study in which the authors reported that patients with HIV will tend to experience stigma to a greater degree than cancer patients resulting from the association of HIV with behaviours that are already marginalized. Sallar (2011:279) also identified with this view and that of Piot (2006:526) in which the author identified stigma as a priority area for the prevention of HIV or AIDS.

The results are also consistent with the assumptions of the attribution theory, which states that individuals are held more responsible for outcomes in situations where they are perceived to have control, and if the outcome is negative, the person receives more blame, and less sympathy and pity than usual (Cobb & de Charbert 2002:545; Cobb 1976:2; Greene 2000:123; Triplet & Sugarman 1987:3), and more so if the cause of illness is negatively viewed as culturally inappropriate (Idemudia 2009:46).

Hypothesis two predicted that there would be a significant difference between types of stigma and the symptoms reported. Results showed that the enacted stigma was the only main significant variable with psychological dysfunctions. The enacted stigma significantly influenced Total GHQ, Anxiety and Depression. The perceived community stigma was significant with depression only. The internal felt stigma did not influence any mental health variable, thereby confirming partly the predicted hypothesis.

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 (Kalichman *et al.* 2009:83; Lindner 2006:3; Lee, Kochman & Sikkema 2002:309; Kalichman *et al.* 2003), hopelessness, and suicidal thoughts (Van Dyk 2001; Heckman, Kochman & Sikkema 2002:442) and discrimination (Simbayi *et al.* 2007:1823). The process and nature of enacted stigma includes overt negative behaviours such as the labelling of people with stigmatized conditions, which can be a very painful experience leading to a severe impact on mental health conditions of the patient.

Limitations of the study

The strengths of this study are that it investigated two groups of patients (HIV and cancer) using psychometrically

reliable and valid measures, and that it included both men and women. However, some limitations remain: systematic sampling could not be used thereby limiting the generalizability of the findings of this study. People can be resilient despite being stigmatized and this characteristic borders on personality variables. Unfortunately, the role of personality was not part of the focus of the study. Further research can be undertaken in this direction.

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, causing Coulter (1979:3) to argue that socio-cultural dimensions are not mere contexts for emotional expression but are primary determinants of the effects of stigmatization and are, therefore, integral to their very constitution. Fernando (1991:5) 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 or not the disease is seen as an illness 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 applied, it is too Eurocentric in approach and intervention.

The failure of the patients, to disclose disease diagnoses, stems from the stigma they experience, and the government or NGOs concerned should begin to put in place how to reduce stigma derived from the general population. If efforts are made to reduce or, if possible, eliminate 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 should be encouraged.

Conclusion

In this study, the following conclusions are made:

- In general, HIV or AIDS patients were found to experience more stigmas than cancer patients
- The actual experience of stigma and discrimination (enacted stigma) is found to be more significant than other forms of stigma
- Anxiety and depression are significant psychopathologies suffered by stigmatized HIV patients. Anxiety and Depression are listed as affective and mood disorders in DSM IV TR
- Perceived community reactions or stigma have a significant effect on depression only
- The internally felt stigma had no effect on any psychological dysfunction.

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Competing interests

The authors wish to declare that we have no financial or personal relationship with anybody or with any institution which may have inappropriately influenced the writing of this article.

Authors' contributions

In this study, E.S.I. (North West University) is the project leader and is responsible for the investigation, study design and manuscript preparation and writing. N.A.M. (Voortrekker Hospital) collected data and did part of the review of literature.

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