

## People Living with HIV/AIDS in the Face of Social Stigmas: The Application of Therapeutic Communication in a Hospital Environment in Sagamu, Nigeria

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### Abstract

*This study examined the application of therapeutic or patient-provider communication in Olabisi Onabanjo University Teaching Hospital (OOUTH) Sagamu, Nigeria. The study sought to find out how health care providers have applied this form of communication to improve the well-being of people living with HIV/AIDS while they experience stigmas in their social relations. The study used the in-depth interview method with 10 people living with HIV/AIDS and five (5) health care providers as respondents. The study was anchored on interpersonal relations theory. Findings revealed that people living with HIV/AIDS actually experience stigmas in their social relations and this causes some psychological depression to them. The study further found that health care providers at OOUTH understand the concept and practice of therapeutic communication as they purposefully apply it in their health care services to improve the well-being of their patients. The people living with HIV/AIDS also confirm that the application of therapeutic communication by health care providers at OOUTH has been a source of hope, which has brought about an improvement to their health in the face of stigmas they experience in their social relations. While this study concludes that therapeutic communication is a modern health communication approach of improving the well-being of patients in general, it recommends that there is a need for more integration of therapeutic communication in order to make health care delivery more sophisticated and productive in Nigeria.*

**Keywords:** HIV/AIDS, therapeutic communication, people living with HIV/AIDS, health care provider, social stigmas, clinical environment

### Introduction

Since the discovery of HIV/AIDS in 1981 (Nigerian Federal Ministry of Health, 2010), it has been a major global health challenge. Its ravaging consequences have had negative imprints on both the infected and affected people. The menace of HIV/AIDS has, over a few decades, attracted the attention of health communication scholars and international funding agencies in order to reduce its scourge. The underlying concern among health communication scholars and practitioners is the need to use effective communication and mass media to improve the HIV/AIDS knowledge, attitude and practice of people in the community. This will enable them to prevent the spread of the virus and enhance proper management for those who have been infected.

In this regards, therapeutic communication has been identified in the field of health communication as an effective approach in the management of HIV/AIDS (Laffan 2002; Miller, 2010). Therapeutic communication is a purposeful form of communication used in helping to build relationship and interaction. It is an interpersonal communication between the healthcare givers and patients during which the health care provider centres on the patient's specific needs to encourage an efficient exchange of information (Bello, 2015).

Health care providers use curative communication skills to provide new information, accurate information, encourage understanding of patient's responses to health troubles, explore choices for care, help in choice making, and facilitate patients' wellbeing (Skinner & Mfecane, 2004). The strength of therapeutic communication is that it provides a secure place for the patient to look at the meaning of the illness and provides the information and emotional support that each patient needs to attain utmost health and well-being (Skinner & Mfecane, 2004). Therapeutic communication works as a treatment for persons in need of health-related care, as it develops therapeutic interpersonal relationship, decreases anxiety, enhances patient compliance and results in an optimistic experience for all involved. Having therapeutic communication skills and provision of a caring relationship that facilitates health and healing are believed to be an essential feature of contemporary healthcare practice (Skinner & Mfecane, 2004). Therapeutic communication, going by its understanding and meaning, has the possibilities of helping to reduce the rate of those living with HIV/AIDS (Miller, 2010).

The negative consequence of stigma has been an ongoing concern to those involved in addressing the HIV/AIDS epidemic globally. The reason for the prevalence of such posture towards those with the infection varies, depending on the area, but it is largely due to lack of education among people. Stigma and discrimination against persons living with HIV/AIDS play significant roles in aggravating the challenges of those living with the virus. Goffman (1963) defines stigma as a deeply discrediting attribute that reduces a person to someone who is in some way tainted and can therefore be denigrated. It is well documented that people living with HIV/AIDS experience stigma and discrimination, and this does not come alone but with challenges for them (Skinner & Mfecane, 2004; Goffman, 2004). The effect goes beyond individuals

infected, both disrupting the functioning of communities and complicating prevention and treatment of HIV (Skinner & Mfecane, 2004).

Therefore, in this study, the authors examined the application of therapeutic communication in the treatment and management process of people living with HIV/AIDS as they face stigmas in their social relations with people. Given the clinical component of this study, the authors adopted Olabisi Onabanjo University Teaching Hospital (OOUTH) Sagamu, Ogun State, as the study location. Olabisi Onabanjo University Teaching Hospital is the only hospital in Ogun State designated as teaching hospital and has a special clinic for people living with HIV. In addition, the choice of OOUTH as the research location for this study is premised on the fact that being a teaching hospital, it is expected to use modern and sophisticated procedures and approaches in its health management. Therefore, the application of therapeutic communication by health care providers who attend to the health needs of people living with HIV/AIDS should, by assumption, be in practice. Hence, the researchers adopted OOUTH to examine the application of therapeutic communication among health care providers in attending to the health need of people living with HIV/AIDS and how this has helped the patients to reduce the psychological issues involved in stigmatisation. Studies have shown that people living with HIV/AIDS actually encounter stigmas and discrimination in their social interactions with people and the application of therapeutic communication has been identified as an effective means to ameliorate the psychological challenges involved in stigmatisation and discrimination among them (Laffan, 2002; Collins, 2009; Miller, 2010).

### **Statement of the Problem**

Stigma and discrimination in respect to HIV/AIDS continue to hamper communication efforts to prevent the spread of infections and engage people in HIV treatment, care and support programmes. Research has linked HIV-related stigma with refusal of HIV testing, non-disclosure to partners and poor engagement in biomedical prevention approaches (Skinner & Mfecane, 2004). HIV/AIDS-related stigma has its own unique qualities. It is believed to be heightened as it is layered upon other stigmas associated with race, gender, homosexuality, drug use and promiscuity (Lee, Kochman & Sikkema, 2002). In essence, stigma not only affects the individual who is carrying the virus, but also increases the exclusion of such people in society. Their participation in communal and social activities is weakened and they are thus limited in term of opportunities. Although the virus may be dangerous, if people living with it are given desired attention, love and proper medication, such people would not become miserable (Lee *et. al.*, 2002). In doing this, health communication scholars, researchers and practitioners have identified the efficacy of therapeutic communication, especially in a clinical environment (Lee *et. al.*, 2002).

Given this background and the need for the integration of therapeutic communication in a clinical environment in the management of people living with HIV/AIDS, this study examines the application to therapeutic communication among

health care providers at Olabisi Onabanjo University Teaching Hospital Sagamu in the course of attending to people living with HIV/AIDS vis-à-vis stigmas they encounter in their social interactions with people in society.

### **Research Objectives**

1. To find out what kind of social stigmas people living with HIV/AIDS experience in their social relations
2. To find out whether health care providers at Olabisi Onabanjo University Teaching Hospital Sagamu understand the concept and practice of therapeutic communication in a clinical environment
3. To find out whether health care providers at Olabisi Onabanjo University Teaching Hospital Sagamu deliberately apply therapeutic communication with people living with HIV/AIDS
4. To examine whether the use of therapeutic communication improves the health and wellbeing of people living with HIV and AIDS

### **Research Questions**

1. What kind of social stigmas do people living with HIV/AIDS experience in their social relations?
2. Do healthcare providers at Olabisi Onabanjo University Teaching Hospital Sagamu understand the concept and practice of therapeutic communication in a clinical environment?
3. Do health care providers at Olabisi Onabanjo University Teaching Hospital Sagamu deliberately apply therapeutic communication with people living with HIV/AIDS?
4. Does the use of therapeutic communication improve the health and wellbeing of people living with HIV and AIDS?

### **Conceptualising Therapeutic Communication**

Therapeutic communication is a major component of health communication practice. The United States Office of Disease Prevention and Health Promotion (2011), states that health communication is the study and use of communication strategies to inform and influence individual and community decisions that affect health. It links the domains of communication and health. The field represents the interface between communication and health and is increasingly recognised as a necessary approach for improving both personal and public health. Health communication can contribute to all aspects of disease prevention and health promotion. The most obvious application of health communication has been in these areas of health promotion and disease prevention (Bello, 2015a). Research has found the improvement of interpersonal and group interactions in clinical situations (for example, between provider and patient, provider and provider, and among members of a healthcare team) through the training of health professionals and patients in effective communication skills (Miller, 2010).

The use of communication is central in health care delivery, health management and public health campaigns, because they bother on improving health lifestyle of people (Bello, 2015a). This, no doubt, underscores the importance of communication as basic to human relations and transactional means. In the recent past, one of the major areas of concern in health communication research was the communication process and the relationship patterns that exist between health care providers and patients (Miller, 2010). This concern was premised on the need to improve the health awareness and attitudes of people through communication process and relationship patterns between healthcare givers and patients (Miller, 2010). This has led to the emergence of the concept of therapeutic communication or what is also called patient-provider communication (PPM). Miller (2010) further argues that the need to build relationships and initiate a heart-to-heart communication system is central to health care delivery and disease management in order to achieve good health behavioural outcomes among individuals and communities. It is important for health care providers to acquire communication skills to improve upon and be able to avoid jargon-laden communication with patients. In this case, communication should be considered as a form of therapy (Collins, 2009).

Therapeutic communication is defined as a face-to-face process of interaction that seeks to advance the physical and emotional well-being of a patient. Health care providers use therapeutic communication techniques to provide support and information to patients (Laffan, 2011). Laffan (2011) further states that therapeutic communication is a necessary technique needed to accomplish medical goals when communicating with a patient. In essence, “correctional healthcare givers must attend to the therapeutic nature of the interactions taking place with patients. Caring, the essence of a healthcare giver–patient relationship must be in the forefront in determining communication and action” (Laffan, 2011 p. 1). From this definition, it can be deduced that communication can be administered in form of a therapy, the same way drugs are administered to patients for prevention, assessment and management of a disease (Bello, 2015b). The concept of therapeutic communication refers to the process in which the healthcare giver consciously influences a client or helps the client to a better understanding through verbal or nonverbal communication. Therapeutic communication involves the use of specific strategies that encourage the patient to express feelings and ideas and that convey acceptance and respect (Sherko, Sotiri & Lika, 2013).

Professional communication is very important for the relationship between the healthcare giver and the patient. They both need to follow rules, use courtesy forms: say hello, goodbye, knock on doors, introduce themselves, make eye contact, smile etc. Building relationships is the cornerstone of caregiver work, particularly with patients who have learning disabilities; communication is a prerequisite to that process (Collins, 2009). It can also be lifesaving. If a patient is informed about what symptoms to mention, a cancer is more likely to be diagnosed and treated in time. Healthcare givers have the most contact with patients, doing connecting work that complements doctors’

consultations. Nurses provide the glue – escorting a patient into the consulting room; identifying with challenges in adhering to lifestyle changes by reporting their own experience; allowing patients to disclose concerns not shared with doctors; being chatty; sharing a joke; and providing explanations where doctors' communication has failed (Collins, 2009, p. 1.). Therapeutic communication includes five levels including intrapersonal, interpersonal, transpersonal, small group communication and public communication levels.

### **Social stigmas and people living with HIV/AIDS**

HIV/AIDS related stigmas can lead to discrimination and the fact is that stigmas and discrimination work together. These stigmas, according to Smit *et. al.*, (2011), come in various forms and may include travel prohibition, denial of healthcare facilities or employment frustration among others. Specifically, literature have documented several forms of social stigmas including but not limited to, (i) self-stigma, which has a damaging effect on the well-being of the person affected (Smit *et. al.*, 2011). Self-stigma affects a person's ability to live positively, limits meaningful self-agency, quality of life, adherence to treatment and access to health services (Smit *et. al.*, 2011; Chong, Mak, Tam & Chung, 2017). (ii) Another social stigma is governmental stigma. This happens in a situation whereby a country's discriminatory laws, rules and policies regarding HIV can alienate and exclude people living with HIV, reinforcing the stigma surrounding HIV and AIDS (Chong *et. al.*, 2017). (iii) Restrictions on entry, travel and stay. As of September 2015, 35 countries have laws that restrict the entry, stay and residence of people living with HIV. Deportation of people living with HIV has potentially life-threatening consequences if they have been taking HIV treatment and are deported to a country that has limited treatment provision (Chong *et. al.*, 2017). Alternatively, people living with HIV may face deportation to a country where they would be subject to even further discrimination - a practice that could contravene international human rights law.

Furthermore, another social stigma being experienced by people living with HIV/AIDS is (iv) healthcare stigma. Health care professionals can medically assist someone infected or affected by HIV, and also provide life-saving information on how to prevent it. However, HIV-related discrimination in healthcare remains an issue and is particularly prevalent in some countries. It can take many forms, including mandatory HIV testing without consent or appropriate counselling (Smit *et. al.*, 2011). Health care providers may minimise contact with, or care of patients living with HIV, delay or deny treatment, demand additional payment for services and isolate people living with HIV from other patients (Smit *et. al.*, 2011). For women living with HIV, denial of sexual and reproductive health and rights services can be devastating. Health care workers may violate a patient's privacy and confidentiality, including disclosure of a person's HIV status to family members or hospital employees without authorisation. Other forms of social stigmas include employment stigma and community and household stigma (Smit *et. al.*, 2011). In the workplace, people living with HIV may suffer stigma from their

co-workers and employers, such as social isolation and ridicule, or experience discriminatory practices, such as termination or refusal of employment (Smit *et. al.*, 2011). Community-level stigma and discrimination towards people living with HIV can force people to leave their home and change their daily activities (Smit *et. al.*, 2011; Chong, *et. al.*, 2017). In many contexts, women and girls often fear stigma and rejection from their families, not only because they stand to lose their social place of belonging, but also because they could lose their shelter, their children, and their ability to survive (Smit *et. al.*, 2011). The isolation that social rejection brings can lead to low self-esteem, depression, and even thoughts or acts of suicide (Smit *et. al.*, 2011; Chong, *et. al.*, 2017).

### Review of empirical studies

HIV-related stigma and discrimination refer to prejudice, negative attitudes and abuse directed at people living with HIV/AIDS. Research has shown that in 35% of countries with available data, over 50% of people were reported as having discriminatory attitudes towards people living with HIV (United Nations Programme on HIV and AIDS – UNAIDS, 2015). Stigma and discrimination also make people vulnerable to HIV. Those who are most at risk to HIV (key affected populations) continue to face stigma and discrimination based on their actual or perceived health status, race, socio-economic status, age, sex, sexual orientation or gender identity or other grounds (UNAIDS, 2017). Stigma and discrimination manifest in many ways. Discrimination and other human rights violations may occur in health care settings, barring people from accessing health services or enjoying quality health care (UNAIDS, 2017). Some people living with HIV and other key affected populations are shunned by family, peers and the wider community, while others face poor treatment in educational and work settings, erosion of their rights, and psychological damage. They also enjoy limited access to HIV testing, treatment and other HIV services (Stangl, Llyod, Brady, Holland & Baral, 2013; Katz, *et al.*, 2013).

The People Living with HIV Stigma Index (2016) documents the experiences of people living with HIV/AIDS indicating that as of 2015, more than 70 countries stigmatised and discriminated against people living with HIV/AIDS. Findings from 50 countries indicate that roughly one in every eight people living with HIV is being denied health services because of stigma and discrimination (UNAIDS, 2017). Also, a study by Makinde (2009) examined the use of language to unravel mysteries surrounding the HIV/AIDS in the selected management campaigns. According to the author, the speech act theory was used to determine the illocutionary voice. Importance of open communication in all relationships was revealed through representative acts to overcome stigma associated with HIV/AIDS. The study revealed that language in this instance has true value unlike its fraudulent use to achieve commercial purposes at the expense of humanistic purpose (Makinde, 2009).

The study of Asogwa and Esimokha (2018) investigated strategic communication as an inevitable tool for HIV/AIDS campaigns in Offa, using a fear

appeal approach. For simplicity, the study employed univariate method of analysis. The results showed that fear appeal-based messages do not significantly pose any behavioural change in the pandemic of HIV/AIDS disease among respondents in Offa, Kwara State. Furthermore, the results confirmed that fear appeal messages in HIV/AIDS campaigns will only succeed in arousing the curiosity of the people to ultimately ignore the fear and engage in high risk behaviour that will predispose them to have HIV/AIDS. Hence, the study concludes that proper use of simple messages to create adequate awareness among people is critical to persuading them to modify their attitude towards HIV/AIDS.

Skinner and Mfecane (2004) in their study show that stigma and discrimination play significant roles in the development and maintenance of the HIV epidemic. The study notes that it is well documented that people living with HIV/AIDS experience stigma and discrimination on an ongoing basis. This impact goes beyond individuals infected with HIV to reach broadly into society, both disrupting the functioning of communities and complicating prevention and treatment of HIV. The research, which reviewed the available scientific literature on HIV/AIDS and stigma in South Africa, as well as press reports on the same subject over a period of 3 years, shows that stigma drives HIV out of the public sight, thereby reducing the pressure for behaviour change (Skinner & Mfecane, 2004). This study further found that stigma also introduces a desire not to know one's own status, which delays testing and accessing treatment. The direct experience of stigma is terrible when you consider how it impacts on those who feel the discrimination. In this case, it is on record that stigma has had particular implications for South Africa given her history of racism and other stigmatising beliefs (Skinner & Mfecane, 2004).

### **Theoretical framework**

In the field of health communication, with reference to patient-provider relationship, one of the most prominent theories is the Peplau's Theory of Interpersonal Relations. This theory was, according to Senn (2013) conceived, developed and popularised by Hildegard Peplau in 1952 as a theory of interpersonal relations between nurses and patients. In the account of Peden (2001), Peplau was a staff nurse, researcher, and educator who espoused that nurses should use nursing situations as a source of observation from which concepts could be derived that are unique to nursing. Primarily, Senn (2013) notes that Peplau was concerned with the conditions of patient in wards, particularly psychiatric patients in asylums during the 1940s and 1950s. In the process, Peplau developed an idea referred to as *talking to patients* which later metamorphosed into therapeutic interpersonal relations theory (Peplau, 1952). This theory was, as noted by Senn (2013), developed not only to be used in treating psychiatric patients but all categories of patients.

Peplau (1952) classified the theory as a middle-range theory within which nursing is defined as the therapeutic relationship between nurse and patients. Therefore, it

necessitated that nurses interact with patients purposefully. According to Peplau (1952), it is believed that “through the device of the therapeutic nurse-patient relationship, the nurse could be the most beneficial to human beings” (Cited in Fawcett, 2010, p. 529). As noted by Fawcett (2010), Theory of Interpersonal Relations focuses on psychological and interpersonal phenomena whereby the nurse can collect pertinent data and facilitate a plan of care by establishing relationships with categories of patients. Senn (2013) states that Peplau emphasises that the terms relations and relationships should not be used as one in the same. This is because the study of what transpires between two people or their relations can be quite elusive. The nurse-patient relationship, as postulated by Peplau (1952), can be expressed as a process with overlapping phases. The theorist, therefore, espouses three identifiable phases involved in Interpersonal Relations Theory, viz: a) the orientation phase, b) the working phase, and c) the termination phase. According to Peplau (1952), the process of communication embedded in this theory is a means to promote favorable changes in patient behaviours. This theory, according to Fawcett (2010), defines health in a broad sense; as the forward movement of the personality and human processes.

Senn (2013) states that “in each of these phases the nurse-patient relationship has certain nurse and patient behaviours and purpose. The nurse uses the nurse-patient relationship to assess the patient’s psychological, emotional, and spiritual needs with learned communication skills, personal strengths, and an understanding of human behaviour” (p. 32). Furthermore, Senn (2013) notes that the result is to generate desirable goals that benefit the patient. In any patient setting, according to Peplau (1952), trust occurs when the patient is confident in the nurse’s conveyance of integrity and reliability. This is premised on the fact that it is through the nurse-patient relationship that the nurse can express empathy toward the patient and help in improving their well-being (Peplau, 1952).

As postulated by Peplau (1952), the initial phase of the theory is known as orientation. This phase, according to the theorist, is when the patient has health-seeking behaviours and the nurse is identified as someone who is qualified to help the patient. This period sets the stage for a more trusting relationship. In the orientation phase, the nurse collects data, makes initial assessments of the patient’s needs, potential, interests, and the patient’s inclination to experience fear or anxiety (Peplau 1952, cited in Fawcett, 2010). In the phase two of Peplau’s theory, which is regarded as the working phase, this phase is so named because most of the work of the relationship occurs in this realm. According to the theorist, this phase has two sub phases; identification and exploitation. Peplau (1952) proposes that the identification stage positions the nurse to assume various personalities including, but not limited to, care provider, the surrogate parent, the educator or the counselor (Cited in Fawcett, 2010). This important phase allows the nurse to use professional knowledge, education, and skill to solve a particular health problem. According to Senn (2013), “this is an important period where the patient

identifies the nurse as consistently helping, providing unconditional care, and providing empathy” (p. 32). The exploitation aspect of this phase implies that the patient takes advantage of all services offered, exploiting the nurse-patient relationship to address treatment goals (Peplau, 1952).

The final phase of the theory, which is called the termination phase, allows the nurse and patient to disengage from the nurse-patient relationship altogether (Peplau, 1952, cited in Senn, 2013). Fawcett (2010) states that at this phase, the nurse summarises the discharge plan and helps the patient organise actions to progress toward new socially interdependent relationships. In the postulation of Peplau (1952), the termination of the nurse-patient relationship enhances the patient’s ability and skill to become more self-reliant in leading a productive healthier life (Cited in Fawcett, 2010).

In relation to the focus of this study, there is a strong relationship between this study and the propositions of the theory of Interpersonal Relations. In this study, the thrust is to examine the application of therapeutic communication by health care providers in improving the well-being of people living with HIV/AIDS while they encounter stigmas in their social relations. The ultimate goal of applying therapeutic communication is to use communication as a therapy with patients, and in the case of people living with HIV/AIDS, this will be a form of therapy to give them hope and assurance that despite their condition, they can still live a good and fulfilled life. This directly resonates with the central theme of the theory of interpersonal relations which Peplau (1952) describes as a middle-range theory within which nursing is defined as the therapeutic relationship between nurse and patients, necessitating nurses to interact with patients purposefully. Hence, the theory focuses on psychological and interpersonal phenomena whereby the nurse can collect pertinent data and facilitate a plan of care by establishing relationships with categories of patients. It is, therefore, pertinent to state that this theory is very relevant to the focus of this study.

### **Research methodology**

For the purpose of this study, the in-depth interview research method was adopted in gathering data needed for the research. In-depth interview method is a qualitative research technique that concerns the use of intensive interviews with a small number of respondents to understand their perspectives on a particular idea, issue, programme, or situation (Rubin & Rubin, 2004; Boyce & Neale, 2006). In-depth interview is essential in research in order to have first-hand information collected from the prime sufferers (in this instance) of social stigmas – people living with HIV/AIDS. The use of an in-depth research technique enables the researcher to ask open-ended questions that elicit further depth of information from the selected respondents. In this study, the in-depth interview method was specifically used in order to explore the experiences of people living with HIV/AIDS in the face of social stigmas and the kind of attention they receive in a clinical environment.

The subjects of interview in this study comprised people living with HIV/AIDS and health care providers at Olabisi Onabanjo University Teaching Hospital Sagamu, Ogun State. Olabisi Onabanjo University Teaching Hospital is the only hospital in Ogun State designated as teaching hospital and has a special clinic for people living with HIV. This implies that there are two sets of subjects targeted for this study. From the official record and as stated by the health care providers interviewed, there are five (5) health care providers at OOUTH HIV/AIDS clinic who are specifically designated to about 1,986 people living with HIV/AIDS at the teaching hospital. The HIV clinic operates an outpatient ward system, where patients are not admitted for treatment. Given that the population of this study comprised people living with HIV/AIDS and health care givers at Olabisi Onabanjo University Teaching Hospital Sagamu, ten (10) out of people living with HIV/AIDS were interviewed while five (5) health care providers were interviewed. The interview session for each interviewee lasted for 60 minutes.

Sample size in in-depth interview has no specific universal number (Baker & Edwards, 2012) but scholars have unanimously agreed that sample size in an in-depth interview research is often smaller than what is obtainable in a quantitative research endeavour (Dworkin, 2012; Ritchie, Lewis, & Elam, 2003). This is because in-depth interviews are often concerned with getting an in-depth understanding of a phenomenon, thereby focusing on meaning (and heterogeneities in meaning) (Crouch & McKenzie, 2006; Dworkin, 2012). This often centres on the how and why of a particular phenomenon, issue, process, situation, subculture, scene or set of social interactions (Dworkin, 2012).

However, several literature have suggested between five (5) and 50 interviewees as adequate sample in an in-depth interview research (Morse, 2000; Ritchie *et. al.*, 2003). Morse (1994) has suggested that five (5) to twenty-five (25) interviewees are adequate as sample size in an in-depth interview method. Other studies suggest at least six (6) to fifteen (15) interviewees should be the smallest acceptable sample size (Bertaux, 1981; Guest, Bunce, & Johnson, 2006; Lee, Woo, & Mackenzie, 2002) In this study, therefore, the sample size aligns with the position of six (6) to fifteen (15) respondents. This is connected to a few numbers of health care providers available for the management of people living with HIV/AIDS at Olabisi Onabanjo University Sagamu, Ogun State. The health care providers were interviewed based on appointment within the hospital while people living with HIV/AIDS were also interviewed within the hospital environment on their clinic day at three different occasions. All the interviewees were purposely and conveniently selected as they were all qualified to be participants in the study. The five health care providers designated to the HIV clinic were purposely selected for interviews given the fact that it was a small number. On the other hand, the 10 people living with HIV/AIDS interviewed were conveniently selected as those who came to the clinic on the days given to the researchers for the interview by the hospital Management were selected. The researchers were given three days to

conduct the interviews and within these three days, a total of 10 people living with HIV/AIDS came for treatment in the clinic and were selected for interview.

Out of the five health care providers interviewed for this research, two of them are nurses, one is a new health care worker while one is a pharmacist and the fifth person is a pharmacy technician. Four of them have experiences that spanned over two decades within the health care industry and may be adjudged capable of delivering resources needed to prosecute this research. For the people living with HIV/AIDS, many have lived with the virus for years, with a couple, who have been living with the virus for about twenty years. So, with their experience in medication and treatment of the virus, their knowledge was brought to the fore in achieving the objectives of the research. In reporting the findings, a consensus was reached with the people living with HIV/AIDS to represent each of them with the acronym: PLWHA with alphabets A, B, C while health care providers are represented thus: HCP A, HCP B and so on.

## Findings

### **People living with HIV/AIDS and different kind of stigmas they experience in their social relations**

Social stigma is a widely known challenge for people living with HIV/AIDS. According to them, it is one major areas of focus for governments in many African countries. They report that many non-governmental organisations have spent billions of Nigerian naira and US dollars in sensitising community people on the need to keep good company with those suffering from the virus. The data gathered from people living with HIV/AIDS show that not so many people in society know about their status, hence, it is difficult for the society to stigmatise against them. A sizeable number of them, however, maintained an opposite stance, as they claimed they have experienced several instances of stigmatisation. For these set of individuals, stigmatisation is real because of what the general public thinks about them. According to people living with HIV/AIDS A (PLWHA A), suicide was contemplated as a result of the huge stigmatisation exposed to. PLWHA A added that it was an encounter with the health care providers that changed that narrative. PLWHA A (personal communication, July, 2018) states that:

I once contemplated the idea of suicide when I first discovered my status. I was scared of what would become of me but when I had the opportunity of going for counselling in the clinic, I was convinced that regardless of the disappointments I had, there was hope for me to live. Since then, I have been living freely and happily.

Another PLWHA disclosed that “a few persons who know about the status in the community were those who had also come for treatment in the clinic. And since they first met at the clinic, they have lived as neighbours in peace” (PLWHA B, personal

communication, July 2018). This can be inferred to mean a situation of “esprit the corp.” Also, PLWHA B states that stigmatisation is normal and can only be reduced to the barest minimum but cannot be totally eradicated. The interviewee added that everyone knew of her status in the neighbourhood and has thus taken the advantage to speak to those in the same situation. According to PLWHA B:

Many people know my status in my community as one who speaks about HIV/AIDS every time. And because I do not feel bad about my status, there is no way people can stigmatise me. I speak up and today, people know me for whom I am and they respect me. Stigmatisation is normal. But, lack of knowledge is the reason for prevalence of the virus among our people. (PLWHA B, personal communication, July, 2018)

For the health care providers, stigmatisation exists in Nigeria, and people have continued to complain of the same situation. They added that due to the orientation of Nigerians about people living with HIV/AIDS, a unit of their clinic is dedicated to counseling of people so that members of the public can have a rethink about the virus and those carrying it. One of the HCPs said specifically while commenting on the reality of stigmatisation, that “HIV does not really count, as it does not kill but, stigmatisation kills.” (HCP A, personal communication, August 2018) All the health care providers interviewed hold that stigmatisation, which causes depression on the part of the infected person, breeds untimely and mysterious deaths. While some take the escape route of suicide to avoid the shame of being seen as having HIV, others have been subjected to emotional torture. Furthermore, in their response to their knowledge on the kinds of social stigmas they face, people living HIV/AIDS note that while stigmatisation is their biggest fear when considering their health status, most of them (PLWHA) have kept their status within their family circle. In their opinion, no body outside their inner circle of family, friends and a few close acquaintances know about their status, hence, it has been easy to control it. Interestingly, most of them have enjoyed massive support from their family members except from a few who have had marital, health and employment stigmatisation. PLWHA A reported that, “since no one knows about my status, I have never had issues with those around me. Only very few of the nurses speak very badly to us but most of them speak kindly and cheerfully” (PLWHA A, July 2018).

In a similar situation, PLWHA D (personal communication, August, 2018) adds that “my husband was surprised when he heard I had HIV, despite the fact he and the children were tested negative. In fact, PLWHA D’s in-law stigmatised her as most of them stayed away from her and avoided interaction with her. “I went through a trauma from my mother-in-law in particular but given several counselling sessions I have attended, I successfully managed the situation otherwise, I would have left the marriage” (PLWHA D, personal communication, August, 2018). In the case of PLWHA

I (personal communication, August 2018), the major stigma she faced was related to employment. “With my status, the fear of losing my job at the moment takes larger part of my mind” (PLWHA I, personal communication, August 2018). Speaking on the travail, PLWHA I (personal communication, August, 2018) states that “I have had to keep my HIV status within myself because I do not want to lose my job. The management of my new place of work is not aware and it is deliberate so as to prevent myself from stigmatisation.” Most of the patients had no idea of their status until either after their spouse’s death or when they got terribly sick and they were compelled to do the test. And these people have lived with the virus for about 10-25 years with a very few who discovered their status within the first five years. While it is true that stigmatisation exists, it is important for “de-stigmatisation” to come to mind of those living with the virus. And as such, as PLWHA B (personal communication, August 2018) believes that stigmatisation will not come from members of the public if people living with the virus do not stigmatise themselves in the first place. “We, therefore, need to see and perceive ourselves as beautiful, strong and successful like every healthy member of the public so that we can have our rightful place in the society” (PLWHA D, personal communication, August 2018).

### **Health care providers’ knowledge and understanding of therapeutic communication in a clinical environment**

While therapeutic communication as a concept and practice may not be well known to a common man on the street, it is a major competence that health care providers need to acquire in order to deliver healthcare services to the people. HCP A (personal communication, August, 2018) stated that much has gone into their training which also enhances the usefulness of therapeutic communication in the discharge of their duties. Recounting the learning process the healthcare providers had gone through to prepare them for the task of taking care of people living with HIV/AIDS, HCP A (personal communication, August 2018) notes further that they “have been sponsored to attend training in handling patients with HIV/AIDS and effective use of therapeutic communication. The training has been very helpful in attending to the patients and understanding their plights.” In the same vein, HCP B (personal communication, August 2018) supported the view of the HCP A that therapeutic communication is a key competence in medical practice. Therapeutic communication is used in therapeutising people living with HIV/AIDS. In the words of this interviewee,

I realised that communication is key in managing patients, hence therapeutic communication strategy should be effectively employed. As a practitioner, I know I must talk to them in a way they would appreciate, in a way they would understand, and I must come to their level and sympathise with their condition (HCP B, personal communication, August 2018)

Furthermore, HCP D (personal communication, August 2018) states that "we employ therapeutic communication from the entry point to the exit point. And we can say here, that it has no limits. When we give our patients time to check back and they don't, we track them. And so far, we can rate therapeutic communication 100% effective in our clinical engagements with our patients." This healthcare professional argues further that,

We use therapeutic communication on every patient. This is done to encourage the patients and give them hope, making them realise that HIV does not kill, but stigmatisation does. This communication skill is acquired in the training facilitated by the Institute of Human Virology in Nigeria, (IHVN) and has been really helpful to foster cordial and mutual relationship between the members of staff and the patients. (HCP D, personal communication, August 2018)

### **Application of therapeutic communication by health care providers at OOUTH and improvement of the well-being people living with HIV/AIDS**

Therapeutic communication has been confirmed to be in use as part of strategic efforts towards fostering cordial and mutual relationship between health care providers and people living with HIV/AIDS. As far as the HCPs are concerned, the application of therapeutic communication is essential and unavoidable in getting the desired results in health care delivery. The Institute of Human Virology in Nigeria (IHVN) has been the body helping to train personnel, arrange for seminars and workshops until the body left Nigeria in December 2017. HCP A (personal communication, August 2018), however, notes that there is an indication that another body is planning to take up the responsibility to keep health care providers abreast of the development in the area of HIV/AIDS and the use of therapeutic communication.

Findings from this study confirm that health care delivery shows more positive results among patients when therapeutic communication strategy is applied. According to the HCP A, (personal communication, August 2018), "therapeutic communication has been very helpful to us in attending to our patients and understanding their plights. This has proven to be useful in managing the well-being of the patients. So, when they come here, they don't leave the same person again. Their psychological being is usually boosted through our interactions." This view is supported by HCP B, (personal communication, August 2018) who maintains that people living with HIV/AIDS need a lot of shared love and patience if the desired results were to be achieved. The same health professional notes further that,

People living with HIV/AIDS need a lot of patience, hence one needs to be very careful in the way one relates with them.

Therapeutic communication is often used to make them feel happy

and to be alive. This will help to improve their psychological well-being and, it has been working effectively. I realised that communication is key in managing patients, hence therapeutic communication strategy should always be employed. As a practitioner, I know I must talk to them in a way they would appreciate, in a way they would understand, and I must come to their level and sympathise with them. (HCP B, personal communication, August 2018)

HCP E (personal communication, August 2018) notes that therapeutic communication is mostly used by the healthcare professionals on a one-on-one basis to improve the psychological well-being of people living with HIV/AIDS. Despite the efficacy of therapeutic communication in a clinical environment, all the health care providers interviewed admit the fact that there are still a few health professionals who are lackadaisical due to unprofessional attitudes towards patients. These set of professionals, according to HCP 3 (personal communication, August 2018), fail to understand that working and attending to people living with HIV/AIDs is a business of empathy.

Considering the importance of building personal and individualised relationship with patients in order to achieve good health outcomes, “therapeutic communication is applied on people living with HIV/AIDS at every encounter” (HCP C, personal communication, August 2018). Further, “we at the HIV clinic of the Olabisi Onabanjo University Teaching Hospital employ therapeutic communication from the entry point to the exit point.” In addition, another health care provider states that, “as for us here, we can say that the application of therapeutic communication has no limits. Therefore, when we give our patients time to check back and if they don't, we make efforts to track them. And so far, we can rate therapeutic communication as 100% effective and has greatly contributed to the well-being of our patients.” (HCP D, personal communication, August 2018)

## **Discussion of findings**

In this study, it was established that people living with HIV/AIDS actually experience a wide range of stigmas in their social relations despite the fact that many of them conceal their status in society. This finding resonates with the study of UNAID (2015) which indicates that in 35% of countries with available data, over 50% of people were reported as having discriminatory attitudes towards people living with HIV. Furthermore, this study has found that people living with HIV/AIDS are exposed to social stigmas. This finding is similar to the findings of Global Network of People Living with HIV (2016) and UNAID (2017). These previous studies, as confirmed by the current study, found that people living with HIV/AIDS experience social stigmas in

their social relations and more specifically, UNAID (2017) indicates that findings from 50 countries indicate that roughly one in every eight people living with HIV is being denied health services because of stigma and discrimination.

Furthermore, as established in this study that people living with HIV/AIDS experience employment-related stigma in society, stigma from family relationship and within the neighborhood, previous studies such as Skinner and Mfecane (2004), Avert (2018), Stangl *et. al.*, 2013; Katz, *et. al.*, 2013 and UNAID (2017) have also established these forms of stigmatisation.

Having established in this study, like other previous studies, that people living with HIV/AIDS actually experience various forms of stigmas in their social relations, the application of therapeutic communication was further confirmed by both health care providers and people living with HIV/AIDS as an effective antidote in boosting the psychological well-being of HIV/AIDS patients. This resonates with the works of Stubbs (1989), Makinde (2009), Bello (2015a) and Esimokah (2018). These previous studies also found efficacy in the use of effective communication and language in the management of people living with HIV/AIDS. In this current study, health care providers at Olabisi Onabanjo University Teaching Hospital have been trained in the use of therapeutic communication, and they constantly apply it with consciousness in their engagement with their patients. Patients (people living with HIV/AIDS) also confirm that the use of therapeutic communication by their care-givers has saved them from serious psychological trauma and prevention of suicide.

In addition, the findings of this study show that with the application of therapeutic communication in improving the well-being of people living with HIV/AIDS vis-à-vis social stigmas, nurses, as postulated by interpersonal relations theory, can be the most beneficial to human beings (Peplau, 1952, cited in Fawcett, 2010, p. 529). In this process, health care providers also assume various personalities including, but not limited to, care provider, the surrogate parent, the educator or the counselor (Peplau, 1952, cited in Fawcett, 2010).

### **Conclusion and Recommendations**

Based on the findings of this study, stigmatisation of people living with HIV/AIDS, though bad, is still common in our society despite several global and national campaigns. One may also identify poor education and poor orientation among members of the public in stigmatising their fellow human beings, people living with HIV/AIDS. Stigmatisation, no doubt, exists in our society vis-à-vis people living with HIV/AIDS, resulting into different levels of psychological traumas. In the face of these social stigmas, it may be concluded that one of the major and effective ways to reduce social stigmas and enliven the hope of people living with HIV/AIDS is the use of therapeutic communication. In this case, communication is administered to them the same way a drug is administered to cure a disease. Furthermore, this study concludes

that health care practice in Nigeria is getting more sophisticated with the integration of therapeutic communication in the professional practice of health care delivery. This is confirmed in the interviews conducted with health care providers working at the HIV/AIDS clinic of Olabisi Onabanjo University Teaching Hospital Sagamu. This study, therefore, concludes that in the nearest future, people living with HIV/AIDS may live a very normal life without the feelings of being traumatised by the negative disposition of members of society if the continuous application of therapeutic communication by health care providers will serve as capacity building and empowerment for people living with HIV/AIDS. Consequently, social stigmas may have little or no effect on them.

This study, therefore, recommends that there is a need for more integration of therapeutic communication in order to make health care delivery more sophisticated and productive in Nigeria. In achieving this, health care providers should place high importance on therapeutic communication capacity building while Hospital Management should also complement their efforts by organising seminars and workshops on capacity building in order to achieve a better health care delivery service.

## References

- Asogwa, C. E. & Esimokha, G. (2018). Strategic communication as an inevitable tool for HIV/AIDS campaigns: Evidence from Offa Community, Kwara State, Nigeria. *Global Media Journal*, 16 (30), 1-8.
- Bello, S. (2015a). Converging points and issues in health communication in new media context.” *Journal of Media and Communication Review*, 1 (1), 1-26.
- Bello, S. (2015b). *Newspaper Coverage of Health Issues in Nigeria: The Frequency of Reporting Malaria, HIV/AIDS & Polio and the Effect of Seeking Health Information on the Health Behaviours of Newspaper Readers*, A Ph.D Thesis in Media & Communication, Submitted to the Department of Media and Communication, University of Canterbury, New Zealand. Retrieved from <https://ir.canterbury.ac.nz/bitstream/handle/10092/11639/Bello%2C%20Semiu%20-%20Final%20PhD%20Thesis.pdf?sequence=>
- Bertaux, D. (1981). From the life-history approach to the transformation of sociological practice. In D. Bertaux (Ed.), *Biography and society: The life history approach in the social sciences* (pp. 29-45). London: SAGE.
- Boyce, C., & Neale, P. (2006). *Conducting in-depth interviews: A guide for designing and conducting in-depth interviews for evaluation input*. Watertown: Pathfinders.
- Chong, E. S., Mak, W. W., Tam, T. C & Chung, R.W. (2017). Impact of perceived HIV stigma within men who have sex with men community on mental health of seropositive MSM *AIDS Care*, 29(1), 118-124.
- Collins, S. (2009). Good communication helps to build a therapeutic relationship. *Nursing Times* 105(24), 11-23.
- Dworkin, S. L. (2012). Sample size policy for qualitative studies using in-depth interviews. *Archives of sexual behavior*, 41(6), 1319-1320. doi: 10.1007/s10508-012-0016-6.
- Fawcett, J. (2010). Contemporary nursing knowledge: *Analysis and evaluation of nursing models and theories* (2nd ed.). Philadelphia: F. A. Davis.
- Federal Ministry of Health. (2010). 2010 National HIV Sero-prevalence sentinel survey. Abuja, Nigeria: Federal Ministry of Health, Nigeria.
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1), 59-82.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*, England: Penguin
- International Conference on Stigma (2017). What is stigma? Retrieved from <http://www.whocanyoutell.org/what-is-stigma/>

- Katz, I. T., Ryu, A. E., Onuegbu, A. G., Psaros, C., Weiser, S. D., Bangsberg, D.R., & Tsai, A.C. (2013). Impact of HIV-related stigma on treatment adherence: Systematic review and meta-Synthesis. *Journal of the International AIDS Society* 16 (3). 13-25.
- Laffan, S. (2011). Therapeutic communication and behavioral management. Retrieved from <http://www.ncchc.org/cnp-therapeutic-communication>
- Lee, D. T. F., Woo, J., & Mackenzie, A. E. (2002). The cultural context of adjusting to nursing home life: Chinese elders' perspectives. *The Gerontologist*, 42(5), 667-675.
- Lee, R., Kochman, A. & Sikkema, K. (2002). Internalized stigma among people living with HIV-AIDS. *Aids and Behaviour*, 6 (4), 309-319
- Makinde, T. (2009). The role of illocutionary force in HIV/AIDS management campaign messages in Nigeria. *Journal of Communication and Media Research*, 1(1), 129-139.
- Miller, N. A. (2010). Ethnicity and doctor-patient communication in Kenya. *African Communication Research*, 3(2), 267-280.
- Okunna, G. & Igebu, D. (2015). Celebrities as brand ambassadors in advertising campaigns: A study of MTN Nigeria advertising campaigns. *Image Maker Public Relations Journal*, 3 (1), 15-30.
- Peden, A. (2001). Hildegard Peplau: The process of practice-based theory development. In M. E. Parker (Ed.), *Nursing theories and nursing practice* (pp. 56-64). Philadelphia: F. A. Davis.
- People Living with HIV Stigma Index (2015). We are the change: Dealing with self-stigma & HIV/AIDS: An experience from Zimbabwe. Retrieved from <http://www.stigmaindex.org>.
- Peplau, H. E., (1952). *Interpersonal relations in nursing*. New York: G. P. Putnam's Sons.
- Rubin, I. S., & Rubin, H. J. (2004). *Qualitative interviewing: The Art of hearing data* (2nd ed.). London: SAGE.
- Senn, J. F. (2013). Peplau's theory of interpersonal relations: Application in emergency *Nursing Science Quarterly* 26(1), 31-35.
- Sherko, E., Sotiri, E. & Lika, E. (2013). Therapeutic communication. *Review Article, JaHR* 4 (7), 10-19.
- Skinner, D. & Mfecane, S. (2004). Stigma, discrimination & the implications for people living with HIV/AIDS in South Africa. *Journal of Social Aspects of HIV/AIDS*, 1 (3), 15-28.
- Smit, P. J., Brady, M., Carter, M., Fermes, R., Lamore, L., Meulbroek, M. Ohayon, M. Thompson, M. (2012). HIV-related stigma within communities of gay men: A Literature Review. *AIDS Care* 24(3-4), 405-412

- Stangl, A.L., Lloyd, J. K., Brady, L. M. Holl, C. E. & Baral, S. (2013). A systematic review of interventions to reduce HIV-related stigma & its crimination from 2002 to 2013: How far have we come? *JIAS* 16 (Supplement 2), 18734. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3833106/>
- UNAIDS (2015). On the fast-track to end AIDS by 2030: Focus on location & population. Retrieved from <http://www.unaids.org>.
- UNAIDS (2017). Make some noise for zero discrimination on 1 March 2017. Retrieved from <http://www.unaids.org>.
- US Office of Disease Prevention & Health Promotion (2004). Health communication. *Healthy People 2010* (1). Retrieved from <http://healthy-people.gov>.

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