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Solution-Focused Therapy in The Management of Psychological Distress Among Newly Diagnosed People Living with HIV/AIDS in Ibadan, Nigeria

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ABSTRACT: *This study investigates the efficacy of Solution-Focused Therapy (SFT) in the management of psychological distress among newly diagnosed people living with HIV/AIDS (PLWHA) in Ibadan, Oyo State, Nigeria. A pretest – posttest control group quasi experimental design with 2 x 2 factorial matrix was used for the study with Health Locus of Control (HLC) as a moderator. Purposive sampling technique was utilised to select three hospitals in Ibadan; and 40 newly diagnosed PLWHA were assigned to SFT (23) and the control (17) group. Data were analysed using analysis of covariance and bonferonni Pair-wise test at 0.05 level of significance. There was significant main effect of treatment on psychological distress of newly diagnosed PLWHA ($F_{(2.33)} = 4.11$, $\tilde{\eta}^2 = 0.15$). The SFT was more effective in the management of psychological distress among the participants. There was also significant main effect of HLC on the psychological distress of newly diagnosed PLWHA. There was significant effect of interaction between treatment and health locus of control on psychological distress of people leaving with HIV/AIDS ($F_{(2.31)} = 10.391$; $\tilde{\eta}^2 = 0.251$). Similarly, there was no significant interaction effect of treatment and health locus of control on psychological distress; $F_{(1,31)} = .220$, $p>0.05$, $\eta^2 = 0.007$. The study recommends that health care providers and policy makers should be sensitive to the fact that people who are infected with HIV do experience a variety of psychological distresses as well as increased depression, hopelessness, anxiety and fatigue.*

KEYWORDS*:* Solution-focused therapy, Health locus of control, Psychological distress,People living with HIV/AIDS

INTRODUCTION

Human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) is one of the best known deadly diseases in the world, due to its devastating impact on communities, families,

children and development. Across the world, the global pandemic of HIV/AIDS has shown itself capable of triggering responses like depression, anxiety, hopelessness, stigma, ostracism, repression and discrimination, as individuals affected (or believed to be affected) by HIV often suffer psychological distress. The fear of persons affected with this disease is that since there is no cure for HIV/AIDS presently, persons contracted are likely to die in short time. The major challenge of the PLWHA is the rapid drop or decline of their body immunity otherwise known as the CD4 counts. This is as a result of the onset of the opportunistic infections combating with the individuals living with HIV/AIDS. Although there are medical interventions for the PLWHAs infections and diseases, but their challenges are more.

Increasing number of studies has shown that more and more infections of the virus are being recorded globally (Olley, Seedat, Nei and Stein, 2004; Emlet, 2007; Chikezie, Otakpor, Kuteyi and James, 2013). According to Ahamefule (2005), human security is being threatened by HIV/AIDS. The virus also destabilises society and the state in various ways. The economically active individuals could succumb to AIDS-related illnesses. This could also lead to families' discomfort and breakaway, workplace stigma, income reduction, and weakening of economy (Opara, 2002). Salihu (2003) observes that HIV/AIDS is the epidemic of stigmatisation, discrimination, rejection, blame and collective denial. These, could make it difficult to effectively tackle the disease in Nigeria. According to Folayan, Brown, Odetoyingbo and Harrison (2004), the reality is that people living with HIV/AIDS (PLWHAS) are stigmatised and discriminated against in the society. They asserted that the repercussions are numerous ranging from fear of being rejected by loved ones, spreading the infection, the denial of any treatment to the difficulty of finding employment or housing. Salihu (2003) again notes that many deaths of people living with HIV/AIDS are not directly from the effect of the disease itself, but rather from their depressed state of mind as a result of loss of hope and ill-treatment from people around them.

Similarly, Idoko (2016) observes that HIV/AIDS victims seem to die earlier because of the psychological distress and emotional trauma they are subjected to at the knowledge of their status as victims. Therefore, people living with HIV/AIDS (PLWHA) are stigmatised, discriminated against socially and are physically isolated and treated with suspicion. These causes could bring about psychological depression, emotional trauma and physiological exhaustion in PLWHA. More than what the treatment and prognosis of HIV/AIDS could engender, is the psychological trauma people diagnosed with HIV/AIDS could face. The psychological distress they manifest after post-HIV diagnosis could be traumatic, harrowing and depressing. Impact of HIV diagnosis, living with chronic illness thereafter if not adhered to antiretroviral medications, side effects of medications

or keeping silence of one's status (disclosure), depressive thoughts of stigmatisation and isolation are all situations PLWHA pass through (Idoko, 2016).

Psychological distress refers to non-specific psychopathology which includes a variety of symptoms such as depression, anxiety, stress and insomnia (Donker, Comijs, Cuijpers, Terluin, Nolen, Zitman and Penninx, 2010). It is known to be associated with lower quality of life, mental and physical morbidity and mortality. Moreover, psychological distress is known to be one probable explanation in mediating the socio-economic gradient in health and mortality (Donker, Comijs, Cuijpers, Terluin, Nolen, Zitman and Penninx, 2010). Psychological distress therefore, represents a dimension of mental ill-health that has neither uniform definitions nor measures. Compared to mental disorder, which refers to categorical clinical diagnoses, psychological distress refers to psychopathology that is less specific. Psychological distress is also considered a dimension of psychopathology that can be measured in simple and cost-effective ways in the general population (Drapeau, Beaulieu-Prévost, Marchand, Boyer, Préville and Kairouz, 2010). It consists of a combination of depressive symptoms, anxiety and perceived stress as well as general sleeping problems. In a review of mental health indicators for mental health monitoring in Europe, psychological distress is defined as a non-specific syndrome that covers constructs such as anxiety, depression, cognitive problems, irritability, anger and obsession-compulsion (Korkeila, 2000). It is also said to be highly co-morbid in human immunodeficiency virus infection/acquired immunodeficiency syndrome (HIV/AIDS) (Adewuya, Afolabi, Ola, Ogundele, Ajibare and Oladipo, 2008, Olisah, Baiyewu and Sheikh, 2010). In this wise, the psychological distress attached to AIDS might not only affect the individual's access to health services and employment, but also, could impact on their well-being, social, and emotional state. Similarly, psychological distress is reported to be common among persons living with HIV/AIDS (PLWHAs) compared with apparently healthy members of the society. The prevalence for depression among PLWHAs vary depending on the setting of the study. For example, rates are said to average between 10% and
30% among……
…….(James, Morakinyo, Eze, Lawani and Omoaregba, 2010). The relationship between depression and HIV/AIDS is complex. It is therefore, theorised that immune change as a result of viral infections may be responsible for depression (Goar, Obembe, Audu and Agbir, 2012). Aina (2007) argues that that psychological distress of one's HIV status may predispose to depression as well as other psychiatric disorders like anxiety, psychosis, and posttraumatic stress. Another possible mechanism is stigma. This is especially common in a developing country like Nigeria, where the illness is highly stigmatized and PLWHAs feel isolated and discriminated against (Monjok, Smesny and Essien, 2009). Though this area has been extensively researched in

developed countries, studies in developing nations are few. With scarce resources and the high mortality recorded from HIV/AIDS in sub-Saharan Africa efforts aimed at reducing this rate should be encouraged.

The Solution-focused therapy was conceived and developed by DeShazer and his colleagues at the Brief Family Therapy Centre in Milwaukee, Wisconsin during the 1980s (de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich and Weiner-Davis, 1986). Solution-focused therapy is one form of brief counselling psychotherapy and it is rooted in the work of hypnotherapist Milton Erickson and family systems therapy (Murphy, 1996). The foundation of this approach is the fundamental belief that people have what it takes to get what they want, and that this potential simply needs to be brought into their consciousness and set in motion (Milner and O'Byrne, 2002). Here, the emphasis is on making the individual believe he/she can bring about the needed change in his/her life. Solution-focused counselling is also known as a non-pathological approach, in that the counsellor forms no preconceived notion about the nature of the problem and does not seek to understand the cause of the problem. In other words, the focus of the counselling is on where the client wants to go, rather than on where they have been. On this, the counsellor takes on a curious, ''unknowing'' stance with the client, letting him or her become the expert on the presenting problem (Sharry, Darmody and Madden, 2002). Given these attributes, solution-focused counselling has drawn great attention from counsellors who seek a time sensitive, positive, and highly pragmatic approach to working with their clients (Murphy, 1996).

The contribution of solution-focused therapy in successful rehabilitation of people experiencing psychological distress has received attention in the clinical literature (Heckman, Kalichman, Kochman, Sikkema, Suhr and Goodkin, 2002). How the intervention may be further explicated promotes questions involving what aspects of coping and support could enhance psychological distress of people living with HIV/AIDS. In view of the complexity involved in psychological distress, it is posited that psychological intervention could strengthen a sense of confidence and empowers patients psychologically, cooperation, positive expectations with respect to resources and goal, in addition to locating tools and negotiating methods to overcome obstacles (Heckman, Kochman, Sikkema and Kalichman, 1999). Solution-focused therapy acknowledges the necessity of utilising the patients' frame of reference when identifying those goals described as important, meaningful or useful to the patient and their rehabilitation context. In addition, several clinicians have applied Solution-focused Behaviour Therapy (SFBT) to group therapy for psychological problems (Frisch, Cornell, Villanueva and Retzlaff, 1992; LaFountain and Garner, 1996). Thus, SFT is a component derivative of SFBT.

In his theory of social learning, Rotter (1954) introduced the concept of locus of control. The original name was "locus of control of reinforcement", but through the years it has come to be known simply as "locus of control" (Grimes, Millea and Woodruff, 2004). Rotter (1954) combined behavioural and cognitive psychology concepts because he believed "reinforcements" (rewards and punishments) are the main determinates in human behaviour. Through reinforcements people begin to formulate beliefs about what causes their behaviours. These beliefs then establish what kinds of attitudes and behaviours people have. The word "locus" means place. Locus of control is a psychological construct that identifies an individual's beliefs about the degree of personal control that can be exercised over his or her environment (Grimes, Millea and Woodruff, 2004). In other words, locus of control is an individual's perception on the cause of events that he/she endures in his/her life. An individual can have either an external locus of control or an internal locus of control. When an individual has an external locus of control he/she believes that they have little control or power to affect personal outcomes of their lives (Wang and Anderson, 1994). On the other hand, if the person has an internal locus of control, it is understood that the individual is able to control and manipulate events that happen in his/her life. In this study, locus of control is conceptualised as Health Locus of Control (HLoC) and utilised as a moderating variable. In effect, external or internal HLoC is used to determine the trend of control (external or internal) of an individual's beliefs about where his/her health lies. In Bachanas, Kullgren, Schwartz, Lanier, McDaniel and Smith's (2001) study on HIV positive adolescents, it was discovered that external LOC was one of several psychosocial processes accounting for the differences in psychological distress and adjustment to HIV. Surprisingly, Bachanas, et al's (2001) finding indicated no significant differences between the two groups in HLOC scores or for overall indicators of psychological distress of people living with HIV/AIDS. Similarly, and in another study, Escoto and Flowers (2003) reported that HIV positive group recorded higher health locus of control HLoC scores and were shown to have greater psychological distress when measured on depressive symptoms, hopelessness, and anxiety.

This study, focuses on solution-focused therapy in the management of psychological distress of the post-HIV diagnosed psychological distress among PLWHA in Oyo State, Nigeria. The study, also utilised health locus of control of the PLWHA dichotomised into external and internal. In driving home, the study, the researchers hypothesised as follows:

1. There is no significant main effect of treatment on psychological distress of newly diagnosed people living with HIV/AIDS in Ibadan,
2. There is no significant main effect of health locus of control on psychological distress of newly diagnosed people living with HIV/AIDS in Ibadan; and
3. There is no significant interaction effect of treatment and health locus of control on psychological distress of people living with HIV/AID in Ibadan.

The three hypotheses were tested for margin of error at 0.05 probability level.

Design

This study employed a pre-test, post-test, control group, quasi experimental design with a 2 x 2 factorial design. The factorial design consists of one treatment group (Solution-focused Therapy) and a control group, the moderating variable of Health locus of control varied at two level, external and internal for health locus of control was also tested.

Population

The population was the people newly diagnosed with HIV (PLWHA) and who attended monthly routine therapy in HIV-designated hospitals in Ibadan, Oyo State.

Sample and Sampling Techniques

Forty (40) newly diagnosed people living with HIV/AIDS were randomly sampled from two of the hospitals (General Hospital, Ring road and Adeoyo Nursing Home, Jericho) in Ibadan. The sample was selected using probability sampling technique from the two public hospitals. The sample was thereafter, randomised into two experimental and control groups as follows, solution-focused group (23) and the control group (17).

Instrumentation

Two research instruments were used in the study. They are; Kessler Psychological Distress Scale and Multidimensional Health Locus of Control Scale. These instruments were translated to Yoruba language at the Department of Linguistics and African languages, University of Ibadan. This was to ensure easy understanding of the contents of the instruments by the English language non – speaking participants.

Kessler Psychological Distress Scale (K10) by Kessler, Barker, Colpe, Epstein, Froerer and Hiripi (2003). The 10-item questionnaire is a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4-week period. The scale was used to evaluate how often participants experienced anxio-depressive symptoms (e.g., nervousness, sadness, restlessness, hopelessness, worthlessness) over the last 30 days. Each item is scaled from 0 (none of the time) to 4 (all of the time) and the total score was used as an index of psychological distress. The scale has an internal consistency reliability of 0.88**.**

Multidimensional Health Locus of Control (MHLoC) Scale: This scale was adapted from 18-item Wallston, Wallston and DeVillis (1978) scale on multidimensional health locus of control. The MHLC has three subscales (One Internal scale and two External scales) which were used by

the researchers. MHLoC response format is on a 6 – point rating measure (6 strongly agree to 1= strongly disagree). The MHLoC scale was used as a moderating instrument. The instrument demonstrates an internal consistency reliability of 0.76.

Procedure for Data Administration and Collection: The researchers made use of an ethical approval from the Oyo State Ministry of Health with reference number AD/13/479/89 for the purpose of the research. The Kesseler psychological distress scale was used to screen participants in the two treatment groups. Eight weeks of intervention sessions on components of Solution-focused Therapy was used for the therapeutic group. The interventions on SFT were administered only on the experimental group by the researchers, while the control group was administered with a placebo intervention on health and hygiene talks. There were pre-test and post-test administrations on the two groups of people living with HIV/AIDS.

Data Analysis

Data were analysed using analysis of Covariance (ANCOVA) at 0.05 level of significance to determine the main and interaction effects of the independent and moderating variable on the dependent variable (psychological distress). Also, Bonferonni Pair-wise analysis was used to determine the mean difference of each of the treatment group.

RESULTS

Hypothesis 1: There is no significant main effect of treatment on psychological distress of newly diagnosed people living with HIV/AIDS.

To test this hypothesis, Analysis of Covariance (ANCOVA) was adopted to analyse the post-test scores of the participants on their psychological distress using the pre-test scores as covariate to ascertain if the post experimental differences are statistically significant. The summary of the analysis is presented in Table 1.

Table 1: Analysis of Covariance summary showing the effects of treatments on psychological distress

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	7389.411[a]	2	3694.706	211.745	.000	.928
Intercept	5.030	1	5.030	.288	.595	.009
Pretest psychological distress	383.139	1	383.139	21.958	.000	.400
Treatment	6190.804	1	6190.804	354.798	.000	.915
Error	575.811	33	17.449			
Total	83224.000	36				
Corrected Total	7965.222	35				

R Squared = .917 (Adjusted R Squared = .913).

Table 1 reveals that there is a significant main effect of treatment on psychological distress; $F_{(2,33)} = 354.798$, $p < 0.01$, $\eta^2 = .915$. Hence null hypothesis is rejected. Therefore, there is a significant difference in the psychological distress behaviour of people living with HIV/AIDS based on treatment and control groups. Size of effect reveals that treatment accounted for 91. 5% ($\eta^2 = 0.915$) change in psychological distress. That is, the variance in treatment group had large effect on psychological distress among people living with HIV/AIDS. For further justification on the margin of difference between the treatment and the control group. The pair-wise comparison using bonferonni was computed and the result is shown in table 2.

Table 2: Bonferonni Pair-wise Comparison showing the significant differences among various between the treatment and control groups

(I) Treatment	(J) Treatment	Mean Difference (I-J)	Std. Error	Sig.[b]
Control group (57.65)	Solution-focused group	26.848*	1.425	.000
Solution-focused group (30.807)	Control group	-26.848*	1.425	.000

Table 2 reveals that after controlling for the effect of pre-psychological distress, experimental group (solution-focused therapy group) (mean= 30.807) recorded the lowest psychological distress

score. This was followed by the control group (mean= 57.65). By implication, solution-focused therapy is more potent reducing psychological distress among people with living with HIV/AIDs than traditional means/ placebo. The coefficient of determination (Adjusted R-squared = .923) overall indicates that the differences that exist in the group account for 92.3% in the variation of psychological distress among people living with HIV/AIDs.

Hypothesis Two: There is no significant main effect of health locus of control on psychological distress of people living with HIV/AID in Oyo State.

To test this hypothesis, Analysis of Covariance (ANCOVA) was adopted to analyse the psychological distress post-test scores of the participants using the pre-test scores as covariate to ascertain the main effect of health locus of control on psychological distress. The summary of the analysis is presented in Table 3.

Table 3: Analysis of Covariance summary showing the interaction effect of treatment and health locus of control on psychological distress

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	7542.721[a]	4	1885.680	138.357	.000	.947
Intercept	49.158	1	49.158	3.607	.067	.104
Pre-test Psychological distress	90.480	1	90.480	6.639	.015	.176
Treatment	5136.374	1	5136.374	376.869	.000	.924
Health locus of control	141.619	1	141.619	10.391	.003	.251
Treatment * Health locus of control	2.992	1	2.992	.220	.643	.007
Error	422.502	31	13.629			
Total	83224.000	36				
Corrected Total	7965.222	35				

R Squared = .947 (Adjusted R Squared = .940)**.**

Table 3 reveals that there is a significant main effect of health locus of control on psychological distress; $F_{(2,31)} = 10.391$, $p < 0.05$, $\eta^2 = .251$. Hence null hypothesis is rejected. Therefore, there is a significant difference in the psychological distress behaviour of people living with HIV/AIDS based on their health locus of control. Size of effect reveals that health locus of control status accounted for 25.1% ($\eta^2 = 0.251$) change in psychological distress; that is, the variance in levels of health locus of control had large effect on psychological distress among people living with HIV/AIDS. For further justification on the margin of difference between the levels of health locus of control, the pair-wise comparison using bonferonni was computed and the result is shown in table 4.

Table 4: Bonferonni Pair-wise Comparison showing main effect of health locus of control on psychological distress among people living with HIV/AID

(I) health locus of control	(J) health locus of control	Mean Difference (I-J)	Std. Error	Sig.[b]
External health locus of control (mean= 45.97)	Internal health locus of control	5.050*	1.567	.003
Internal health locus of control(mean= 40.92)	External health locus of control	-5.050*	1.567	.003

Table 4 reveals that after controlling for the effect of pre-test psychological distress, participants with internal health locus of control (mean= 40.92) recorded the lowest psychological distress score, followed those with external health locus of control (mean= 45.97). By implication, psychological distress thrives among people with living with HIV/AIDs who have external locus of control.

Hypothesis Three: There is no significant interaction effect of treatment and health locus of control on psychological distress of people living with HIV/AID in Oyo State.

To test this hypothesis, Analysis of Covariance (ANCOVA) was adopted to analyse the psychological distress post-test scores of the participants using the pre-test scores as covariate to ascertain the interaction effect of treatment and health locus of control on psychological distress. The summary of the analysis is presented in Table 3 above. Table 3 further shows that there is no significant interaction effect of treatment and health locus of control on psychological distress; $F_{(1,31)} = .220$, $p > 0.05$, $\eta^2 = 0.007$. Hence the null hypothesis is not rejected. This implies that health locus of control did not significantly moderate the effect of treatment on psychological distress.

DISCUSSION

This study examined the effect of solution-focused therapy in the management of psychological distress among of diagnosed people living with HIV/AIDS in Ibadan, Oyo State, Nigeria. With this as the main experimental thrust of the study, we developed three hypotheses through which we subjected the independent and moderating measures to the dependent measure (psychological distress). In our fist hypothesis, we predicted that there would be no significant main effect of treatment on the experimental group. The analyses indicated that there was a main significant difference in the psychological distress of people living with HIV/AIDS after the treatment, solution-focused ($F_{(2,33)} = 354.798$, $p< 0.01$, $\eta^2= .915$). Size of effect also reveals that treatment accounted for 91. 5% ($\eta^2= 0.915$) in the change in psychological distress. That is, the variance in treatment group had large effect on psychological distress among people living with HIV/AIDS. More than this, we also tested for margin of difference between the experimental and control groups using bonferonni pair-wise comparison. This, we got to know that after controlling for the effect of pre-psychological distress, experimental group treated with solution-focused therapy (mean= 30.807) recorded the lowest psychological distress score, followed by the control group (mean= 57.65). The implication of this is that solution focused therapy has the potency to reduce psychological distress among people with living with HIV/AIDS than traditional the placebo given to those in the control group. That explained, the coefficient of determination (Adjusted R-squared = .923) indicated that the differences that existed in the group account for 92.3% in the variation of psychological distress among people living with HIV/AIDs. On this and given the statistical nods reported, it is safe to conclude that it would be instructive to consider solution-focused therapy in the management of psychological distress of people living with HIV/AIDS. Our finding is in congruent with the findings of Knekt (2007), who reported the efficacy of solution-focused therapy in bringing about change in clients' behaviours in respect of problematic feelings, cognitions, and/or interaction. In the same vein, we can also link up our finding with that of McGee, Del Vento and Bavelas (2005) who discovered that clients exposed to solution-focused therapy intervention reported less psychological distress. Further to the above, Ziegler and Hiller (2001) also affirm the empirical contention that solution-focused intervention is effective in helping clients to be adjusted and re-direct their future. This is expected given the reality of the fact that being HIV positive is not only psychologically disturbing, it could also be emotionally debilitating. This accounts for the contention of Ziegler and Hiller (2001) that psychological intervention would help the client to think of a desirable future and map out the small and large changes necessary for adjustment.

In the second hypothesis, we predicted that there would be no significant main effect of health locus of control on psychological distress of people living with HIV/AIDS. Our finding reveal that after controlling for the effect of pre-test, participants with internal health locus of control (mean= 40.92) recorded the lowest psychological distress score. This was followed by those with external health locus of control (mean= 45.97). This implied that psychological distress thrives among people with living with HIV/AIDs who have external health locus of control. Similarly, our finding shows that there is a significant main effect of health locus of control on psychological distress of

people living with HIV/AIDS ($F_{(2,31)} = 10.391$, $p< 0.05$, $\eta^2= .251$). The size of effect reveals that health locus of control status accounted for 25.1% ($\eta^2= 0.251$) change in psychological distress. That is, the variance in levels of health locus of control had large effect on psychological distress among people living with HIV/AIDS. On further justification on the margin of difference between the levels of health locus of control, the pair-wise comparison using bonferonni shows that after controlling for the effect of pre-test psychological distress, participants with internal health locus of control (mean= 40.92) recorded the lowest psychological distress score, followed by those with external health locus of control (mean= 45.97). From the above findings, it is evident that personality characteristic such as locus of control is related to how people, especially those living with HOV/AIDS cope with psychological distress (Gultekin and Bayhan, 2011). Our finding, is also related to the one reported by Gultekin and Bayhan (2011) in which they reported that an internal locus of control led people to adopt active coping strategies by contributing to a sense of self-confidence needed to confront problems directly. At a minimum, our finding implied a strong need for people living with HIV/AIDS to develop strong health locus of control.

And lastly, the third hypothesis of the study predicted that there would be no significant interaction effect of treatment and health locus of control on psychological distress of people living with HIV/AIDS. On this, finding confirmed the prediction of no significant interaction effect ($F_{(1,31)} = .220$, $p>0.05$, $\eta^2= 0.007$). This implies that health locus of control did not significantly moderate the effect of treatment on psychological distress. Evidence from previous studies (Massie, Lloyd-Williams and Irving (2011); Ibbotson, Maguire and Selby, (2006), found an interactive effect of Health Locus of Control (HLC) orientations for persons infected with HIV. However, among adult samples, the result shows a higher internal HLC and a lower external HLC, whereas male patients tended to have higher external health locus of control HLC. Among adults, individuals with high external HLC may have advantages for their emotional adjustment, as patients who do not try to control their condition were able to minimize their level of frustration. Also, individuals who are diagnosed with HIV/AIDS tend to have high internal HLC which indicates that they believe their health condition resulted from their own behaviours and capabilities. Akin to this, is the finding of reported by Nazlican, Akbabaand Okyay (2012) in which they contended that in medical situation, only a little personal control is possible. According to the duo, patients are more likely to be reliant on external sources of control, such as doctors or significant others (e.g. family) than on internal sources. One possible explanation for this finding is related to the nature of HIV/AIDS and its management process. The perceived uncontrollable nature of HIV/AIDS and the uncertainty of treatment outcomes might reduce patients' beliefs in personal control over their illness. In addition to this contention, is our observation of the study's participants who were in an advanced stage of psychological wellness having being exposed to the psychological intervention (solution-focused therapy). This may lead to an increased belief in external forces among the participants in the determination of their health condition.

CONCLUSION AND RECOMMENDATIONS

This article concludes on the efficacy of solution-focused therapy in the management of psychological distress of diagnosed people living with HIV/AIDS. This does not only validate the efficacy of solution-focused therapy, it also, gives an empirical nod to the intervention. And instructively too, the findings reported in the study, provide a further strand of research on a larger scale. More important are the implications of the findings to counselling and psychotherapy practices which is in line with the call for complimentary mode to medicine. While antiretroviral medications are efficacious and could provide physiological relief to people living with HIV/AIDS, they could not address the psychological and emotional turmoil such people are going through. Health care providers and policy makers should be sensitive to the fact that people who are infected with HIV do experience a variety of other psychological distresses as well as increased depression, hopelessness, anxiety and fatigue. Thus, counselling and clinical psychologists, could in the context of the findings reported in the study, draw some psychotherapeutic interventions which could be used to manage psychological distress of people living with HIV/AIDS. The merits of this could further advance care for such people.

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