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Roles of Discrimination and Self-Esteem on Deliberate Self-Harm among People Living With HIV in Anambra State

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Abstract
The study explored roles of discrimination and self-esteem on deliberate self-harm among people living with HIV in Anambra State. In the study 128 People living with HIV served as participants. They were drawn from Federal Medical Centre, Onitsha (Inpatients and Outpatients), and Nnamdi Azikiwe University Teaching Hospital, Nnewi, Anambra State. Purposive sampling technique was used to select the hospitals and systematic sampling technique was used to select the participants. The participants' age ranged 24 to 69 years with mean age of 42.68 and standard deviation of 11.55. The gender data revealed that 71(55.5%) were males and 71(55.5%) were females. Three instruments were used: Perceived Discrimination Scale, Rosenberg Self-Esteem Scale and Self-Harm Inventory. The study adopted correlational design and Multiple regression statistics. The study revealed that perceived discrimination indicated significant role on deliberate self-harm among people living with HIV at ($F_{1, 85}$) = 29.55, p<.05. Self-esteem showed significant role on deliberate self-harm among people living with HIV at ($F_{1, 85}$) = 11.49, p<.05. Perceived discrimination and self-esteem had significant interaction effect on deliberate self-harm among people living with HIV at ($F_{1, 85}$) = 6.43, p<.05. Therefore, the study recommends that psychologists should be engage for psychosocial support to people living with HIV. Their services will help reduce deliberate self-harm triggered by discrimination and low self-esteem.

Keywords: discrimination, self-esteem and deliberate self-harm

Introduction

Deliberate self-harm (DSH) is a public health concern, particularly among people living with HIV. This indicates that people living with HIV (PLHIV) experience higher rates of mental health issues, such as depression and anxiety, which can contribute to deliberate self-harming behaviours (Pillay et al., 2016). In Nigeria, the prevalence of HIV remains a pressing issue, with approximately 1.9 million people estimated to be living with the virus (UNAIDS, 2021).

The psychosocial challenges faced by PLHIV, including social ostracism, often hinder their access to mental health services, resulting in untreated psychological distress (Adelekan et al., 2019). Study have shown that the intersection of HIV-related stigma and mental health issues significantly increases the risk of deliberate self-harm, highlighting the need for targeted interventions (Adebayo et al., 2020)

Deliberate self-harm is the intentional act of injuring oneself, whether through cutting, burning, or other means, without the intention to end one's life (Hawton et al., 2012). This behaviour often arises from deep emotional distress and is frequently observed in individuals struggling with mental health issues. While these acts can be linked to suicidal thoughts, they do not necessarily lead to death. Instead, they reflect a person's emotional turmoil and can manifest in various ways, such as superficial self-mutilation or self-wounding.

However, the motivations behind deliberate self-harm are complex and varied; because research suggests that individuals who engage in these behaviours often experience feelings of impulsivity, low self-esteem, depression, and anxiety (Kiekens et al., 2015). For instance, scholars have described deliberate self-harm as actions taken with non-fatal outcomes, such as cutting or overdosing on substances beyond the recommended dosage (Holliday, 2017; Robinson, 2016).

Moreover, those who harm themselves may adopt a self-blaming coping style, leading to negative self-perceptions (Herpertz et al., 1997; De Leo & Heller, 2004, as cited in Fliege et al., 2009). Therefore, it is important to note that while there is often a correlation between self-harm and other harmful behaviors—like substance abuse—this does not imply causation. For example, someone might engage in deliberate self-harm as a response to perceived discrimination, rather than as a direct result of substance use.

Perceived discrimination consists of actions or omissions that are derived from stigma and directed towards those individuals who are stigmatized. Discrimination, as defined by UNAIDS (2000) in the Protocol for Identification of Discrimination against People Living with HIV, refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group—in the case of HIV and AIDS, a person's confirmed or suspected HIV-positive status—irrespective of whether or not there is any justification for these measures.

HIV-related discrimination may occur at various levels (UNAIDS, 2000). There is discrimination occurring in family and community settings, which has been described by some writers as 'enacted stigma'. This is what individuals do either deliberately or by omission so as to harm others and deny to them services or entitlements. Examples of this kind of discrimination against people living with HIV include: ostracization, such as the practice of forcing women to return to their kin upon being diagnosed HIV-positive, following the first signs of illness, or after their partners have died of AIDS; shunning and avoiding everyday contact; verbal harassment; physical violence; verbal discrediting and blaming; gossip; and denial of traditional funeral rites.

According to Aggleton et al. (2005) there is discrimination occurring in institutional settings—in particular, in work-places, health-care services, prisons, educational institutions and social-welfare settings. Such discrimination crystallizes enacted stigma in institutional policies and practices that discriminate against people living with HIV, or indeed in the lack of antidiscriminatory policies or procedures of redress. Examples of this kind of discrimination against people living with HIV include the following: Health-care services reduced standard of care, denial of access to care and treatment, HIV testing without consent, breaches of confidentiality including identifying someone as HIV-positive to relatives and outside agencies, negative attitudes and degrading practices by health-care workers. More so, often HIV patients are denied of employment based on HIV-positive status, compulsory HIV testing, exclusion of HIV-positive individuals from pension schemes or medical benefits. Similarly, in schools' HIV-affected children are denied of entry, or teachers often face dismissal; in prisons, mandatory segregation of HIV-positive individuals, exclusion from collective activities is witnessed.

At a national level, discrimination can reflect stigma that has been officially sanctioned or legitimized through existing laws and policies, and enacted in practices and procedures (Aggleton et al., 2005). These may result in the further stigmatization of people living with HIV and, in turn, legitimate discrimination because discrimination also occurs through omission, such as the absence of, or failure to implement, laws, policies and procedures that

offer redress and safeguard the rights of people living with HIV. This inability to safeguard their rights at times affects their self-esteem.

Self-esteem is the degree of self-approval by an individual (Okwaraji et al., 2019). According to Udeze, et al. (2023) self-esteem is a subjective personal valuation. It shows a cognitive attitude and emotional feeling about one's own ability, significance, and worth (Kwon et al., 2018). This means that self-esteem is related to feelings and thinking of one individual about his own value and competencies, which reflect a positive or negative attitude about himself. Moreover, self-esteem is crucial and is a cornerstone of a positive attitude towards living. It is very important because it affects how one thinks, acts and even how a person relates to other people. Low self-esteem means poor confidence and that also causes negative thoughts which mean that the individual is likely to give up easily rather than face challenges.

Hence, a person with low self-esteem is said to pay more attention on negative sides of his life and will not think positively, unlike those with high self-esteem (Blascovich & Tomaka, 1991; Hewitt, 2009). Researchers believed that low self-esteem often fueled depressive symptoms among diverse populations living with HIV. Due to low self-esteem in HIV positive individuals may arise from rejection, problems of social identity and other physical concomitants of HIV (Van Dyk, 2008).

Theoretical Framework

The interpersonal theory by Joiner (2005) served as theoretical framework guiding the study because it anchored the study variables perceived discrimination, self-esteem, and deliberate self-harm. The IPTS proposed that an individual will engage in deliberate self-harm behaviour if he or she has both: a) the desire to die; and b) the capability to act on that desire. Unlike other theories on deliberate self-harm, the IPT underscores the critical difference between deliberate self-harm idea and deliberate self-harm behaviour. In other words, IPT not only addresses who wants to attempt to harm themselves, but who can have an idea to harm themselves (Ribeiro & Joiner, 2009).

According to the theory, deliberate self-harm results from the convergence of two interpersonal states; perceived burdensomeness (e.g., the feeling of being a burden on others) and thwarted belongingness (e.g., feeling alienated or socially isolated from friends, family or other valued social circles and perceived discrimination). The third variable, the capacity to carry out the act of deliberate self-harm, refers to the acquired capability for self-harm due to low self-esteem. This includes habituation to pain and fearlessness about deliberate self-harm that is learned over time (Van Orden et al., 2010). The IPT appears well suited to understand deliberate self-harm in later life given the increased likelihood for dependence on others due to functional impairment (e.g., burdensomeness) and the increased likelihood for diminished social networks (e.g., belongingness) among people living with HIV.

Perceived burdensomeness is the perception that one's existence is a burden to family, friends, and/or society (Joiner, 2009). This view is in fact a misperception, in that the person's death will make others "better off". Several studies show associations between the concepts of feeling like a burden to others and deliberate self-harm behaviour. In a study on psychiatric patients at risk for deliberate self-harm, a feeling of being a burden on others was among the ten strongest risk factors (Motto & Bostrom, 1990). Other research has shown similar conclusions, even after controlling for powerful predictors such as hopelessness (DeCatanzaro, 1995; O'Reilly et al., 1990; Van Orden et al., 2006). However, fewer studies have considered the perspective of the PLHIV receiving care and their experience of burdensomeness (Cousineau et al., 2003). Perceived burdensomeness may be more likely to occur in later life as dependence on formal and informal supports is also likely to increase.

Thwarted Belongingness: When social connectedness and the need to belong are not met: A state of thwarted belongingness is said to ensue (Van Orden et al., 2010). The concept of thwarted belongingness is composed of two dimensions: loneliness (e.g., feeling disconnected from others) and the absence of reciprocally caring relationships (e.g., feeling both cared about, and demonstrating care for another).

As noted above, deliberate self-harm is higher among those with little or no social connections. This may include adults who live alone, have no community involvement, and/or no ties to social engagement opportunities, such as through work place connections (Heisel, 2006; Kennedy et al., 1996; Rubenowitz et al., 2001). Thwarted belongingness in later life,

including feeling lonely and lacking a reciprocally caring relationship, may arise following common late-life transitions that decrease the size of one's social support network (e.g., Living with HIV, relocation to care facilities, adult children moving away). Thwarted belongingness is said to be a dynamic state, rather than a stable trait; therefore, it assumes that an individual's degree of feeling like they belong will vary over time, as does the magnitude of these feelings because perceived discrimination (Van Orden et al., 2010).

Acquired Capability: As the words suggest acquired capability is the ability to engage in deliberate self-harm: This construct involves a decreased fear of death and increased physical pain tolerance. It is the construct that moves an individual from thinking or wanting to engage in deliberate self-harm intentionally because of feeling of low self-esteem (Cukrowicz et al., 2011). Acquired capability is necessary precursors to serious deliberate self-harm according to the theory. Joiner (2005) suggested that the ability to enact lethal self-injury is "acquired", namely, through practice. In other words, to overcome the most basic instinct of self-preservation one must also overcome the fear that accompanies suicide, sometimes through physically hurting oneself (e.g., cutting), practicing to load a gun, measuring a toxic overdose of a drug, practicing tying a noose, or standing on the edge of a bridge (Joiner, 2005).

According to the theory, through this form of habituation to pain and self-esteem, an individual works up the "courage" or capability to engage in deliberate self-harm. The principles of the acquired capability construct are based on Solomon and Corbit's (1974) Opponent-Process Theory, which suggests that with repeated exposure to a stimulus, the reaction to that stimulus changes over time such that it loses its ability to elicit the original response. Instead, the emotional effects of the opposite process become strengthened or amplified (Solomon, 1980). For example, bungee jumping is likely to elicit a fear response, yet with repeated exposure, the fear of jumping subsides and feelings of exhilaration becomes amplified (i.e., the opponent process). With repeated exposure to what was originally a painful or fear-inducing experience (e.g., self-injury), the experience becomes less frightening and may be a source of emotional relief. It is hypothesized that this process renders an individual capable to engage in previously frightening and painful behaviours, which in turn results in fearlessness in the face of death. In addition, the acquired capability construct also states that individuals have an elevated tolerance to physical pain to proceed with deliberate

self-harm that would otherwise be agonizing to most (Joiner *et al.,* 2009; Van Orden *et al.,* 2010).

Method

Participants

The study used 88 People living with HIV as participants. They were drawn from Onitsha General Hospital and Enugwu-Ukwu General Hospital (Indoor and outdoor patients). The gender data revealed that 50(56.8%) were males and 38(43.2%) were females. Ages ranged from 23 to 24years with mean age of 42.77 and standard deviation of 11.77. Educational level data showed that 26(29.5%) had B. Sc and above, 34(38.6%) had HND, 18(20.5%) had OND/NCE, and 10(11.4%) had SSCE. Marital data revealed that 26(29.5%) were married, 24(27.3) were single, 10(11.4%) were separated, 18(20.5%) were widowed, and 10(11.4) were divorced. Occupational data indicated that 26(29.5%) were into business, 26(29.5%) were civil servants, 18(20.5%) were students and 18(20.5%) were artisans. Purposive sampling technique was used to select the participants and hospitals because the hospitals and participants provided needed criteria and knowledge for the study.

Instruments

Three instruments were used: Perceived Discrimination Scale, Rosenberg Self-Esteem Scale and Self-Harm Inventory.

Perceived Discrimination Scale

Developed by Williams et al. (1997), the 20-item Perceived Discrimination Scale measures how often people feel that others treat them badly or unfairly on the basis of race, ethnicity, gender, age, religion, physical appearance, sexual orientation, or other characteristics. The scale covers discrimination in different areas of life, including at school, at work, and in one's neighborhood. The 20-item Perceived Discrimination Scale has two subscales: The Lifetime Discrimination Scale and the Daily Discrimination Scale. Respondents complete the 11-item Lifetime Discrimination scale by indicating how many times they have been treated unfairly over the course of their lives (e.g., "You were discouraged by a teacher or advisor from seeking higher education"). To score this scale, researchers add the number of events that happened at least once for the respondent. Higher scores on this scale mean more experiences of lifetime

discrimination. The 9-item Daily Discrimination scale captures respondents' experiences with unfair treatment in their day-to-day lives (e.g., "You are treated with less courtesy than other people"). Respondents complete the Daily Discrimination Scale by indicating how often they feel discriminated against on a 1 to 4 scale (1 = often; 2 = sometimes; 3 = rarely; 4 = never). To score this scale, researchers reverse code all items and add the scores together, so that higher scores mean more frequent experiences of discrimination. The subscales have Cronbach's coefficient alpha ranging from 0.89 (Lifetime Discrimination Scale) to 0.93 (Daily Discrimination Scale). The researchers used the participants of the study to determine the Cronbach alpha and validity of the instrument. Cronbach alpha of 0.88 with mean norm of 34.90 and standard deviation of 2.83 was determined for the overall scale. The subscales has Cronbach alpha of 0.82 with mean norm of 18.52 and standard deviation of 1.98 for life time discrimination, and Cronbach alpha of 0.78 with mean norm of 21.53 and standard deviation of 1.98 for daily discrimination. For the validity, PDS was correlated with Self-Harm Inventory by Sansone and Sansone (2010) and concurrent validity of r= .51 was confirmed.

Rosenberg Self-Esteem Scale

The Rosenberg (1965) Self-Esteem Scale (RSES) is a 10-item measure of self-respect and self-acceptance. Items (e.g. 'I feel that I am a person of worth, at least on an equal plane with others') are rated using a four-point response scale (1 = Strongly disagree; 4 = Strongly agree), half of which are reverse scored (Items 2, 5, 6, 8, 9). The developers reported an alpha coefficient of 0.78 for the internal consistency reliability of the 10-items. Findings of various studies support the construct validity of the RSES .38, and estimated internal consistency reported for the RSES in prior research has been α 0.80. Udeze, et al. (2023) obtained an internal consistency (Cronbach's alpha) reliability of 0.67. The researchers used the participants of the study to determine the Cronbach alpha and validity of the instrument. Cronbach alpha of 0.82 with mean norm of 18.52 and standard deviation of 2.87 was determined. For the validity, PDS was correlated with Self-Harm Inventory by Sansone and Sansone (2010) and divergent validity of r= .03 was confirmed.

Self-Harm Inventory

The scale is a 22-item self-report inventory developed by Sansone and Sansone (2010) to assess patients' history of self-harm behaviours. Each item requires a "yes" or "no" response. The SHI is scored by counting a point for every "yes" response. Scores range from 0, indicating

no self-harm behavior, to 22, indicating every self-harm behaviour addressed in the inventory. The scale has excellent internal consistencies of 0.84 with Mean score of 7.31 and standard deviation of 4.80. And_concurrent validity of(r = .55) while correlating SHI scores and self-reported numbers of medically self-sabotaging behaviours scale. The researchers used the participants of the study to determine the Cronbach alpha and validity of the instrument. Cronbach alpha of 0.91 with mean norm of 30.18 and standard deviation of 6.13 was determined. For the validity, SHI was correlated with Perceived discrimination Scale by Williams et al. (1997) and concurrent validity of r= .39 was confirmed.

Procedure

Before the commencement of the study, the researchers recruited two research assistants that works in the hospitals used for the study and these assistants were trained on the sensitivity of the study, and how to administer the instruments. The researchers and the assistants obtained permission from the hospitals ethics and management board and also sought informed consent of the participants. After obtaining permission, the researchers and the trained assistants engaged the participants with a self-introductory letter that explained the objectives of the study. The researchers informed the participants that they have the right to withdraw from the study anytime they decide. On the whole 100 copies of questionnaire were administered for the study, while 93 were retrieved and 88 were properly answered. Ethically, informed consent of the participants were obtained before instruments was issued to them. Secondly, the participants were assured of confidentiality and anonymity of their identity.

Design and Statistics

The study adopted correlational design because the objective of the study was to establish the relationship among perceived discrimination, self-esteem and deliberates self-harm. Multiple regression was used in testing the predictive effect of the variables in the study (perceived discrimination and self-esteem on deliberates self-harm).

Result

This section presented the data analysis of the study.

Table: Multiple Regression Statistics of Discrimination, Self-Esteem and Deliberate Self-Harm

Predictors	R^2	Adj. R^2	B	Std. E.	Df	F	t	β	95% CI Lower	Upper
	.730	.728								
Constant			58.97	2.73	5, 82	72.44	21.53		55.18	54.86
Life time Discri.			3.02	.06			47.38	1.12*	3.15	4.90
Daily Discrimin.			3.75	.19			19.83	2.16*	4.12	5.38
Self-esteem			-1.28	.11			-10.21	-.61*	-1.75	-1.50

From the table above, the results showed that life time discrimination had positive prediction on deliberate self-harm and was stronger for PLHIV with high life time discrimination at ($F5_{,82}$) β= 1.12*, t = 47.38, at p<.05. Daily discrimination had positive prediction on deliberate self-harm and was stronger for PLHIV with high daily discrimination at ($F5_{,82}$) β= 2.16*, t = 19.83, at p<.05. This means that as life time and daily discrimination increase deliberate self-harm increase. Self-esteem had negative prediction on deliberate self-harm at ($F5_{,82}$) β= -61*, t = -10.21, at p<.05

Jointly, discrimination and self-esteem had significant and positive joint prediction on deliberate self-harm with R^2 = .730, adjusted R^2=.728, ($F5_{,82}$) = 72.44, p<.05. This showed that the overall model jointly made significant contribution to deliberate self-harm at 73.0%.

Summary of Findings

1. Perceived discrimination indicated significant positive prediction on deliberate self-harm among people living with HIV.
2. Self-esteem showed significant negative prediction on deliberate self-harm among people living with HIV.
3. Perceived discrimination and self-esteem had significant interaction effect on deliberate self-harm among people living with HIV.

Discussion

The findings of the study affirmed that perceived discrimination indicated significant positive prediction on deliberate self-harm among people living with HIV. This finding is line with Liu et al. (2023) study that noted that perceived discrimination significantly predicted suicidal ideation. That social support, depressive symptoms, and NSSI acted as mediators. Specifically, the role of social support was more significant among impoverished individuals, while the role of depressive symptoms was more significant among nonimpoverished individuals. More so, the finding is in line with Askeland et al. (2022) study that confirmed perceived discrimination was associated with increased psychological distress, and higher odds of thoughts of self-harm and suicidal ideation.

This makes Mao et al. (2022) to states that perceived discrimination had a direct positive effect on suicidal ideation; social support and loneliness partially mediated the relationship between perceived discrimination and suicidal ideation. Specifically, perceived discrimination was positively associated with suicidal ideation via social support and loneliness separately, and had a serial association through both social support and loneliness. Thus, perceived discrimination may have influenced and self-harm and suicidal ideation through both social support and loneliness. These affirmations from previous studies showed that increase in perceived discrimination means increase deliberate self-harm. Theoretically, this makes Van Orden et al. (2010) believed that perceived discrimination and thwarted belongingness is said to be a dynamic state, rather than a stable trait; therefore it assumes that an individual's degree of feeling like they belong will vary over time, as does the magnitude of these feelings because of perceived discrimination and thwarted belongingness.

This finding denotes that individuals with HIV often face discrimination from society, which can lead to feelings of isolation, shame, and worthlessness. Such negative experiences can exacerbate mental health issues, including depression and anxiety, which are already prevalent among this population. The internalization of this discrimination may lead individuals to view themselves through a negative lens, increasing the likelihood of engaging in self-harming behaviours as a maladaptive coping mechanism to manage emotional pain.

Moreover, when individuals feel marginalized and unsupported, they may resort to self-harm as a way to express their distress or to regain a sense of control over their lives. The chronic stress associated with discrimination can also trigger physiological responses that heighten vulnerability to self-destructive behaviors. Additionally, the lack of social support due to discrimination can diminish resilience, leaving individuals without the necessary resources to cope effectively with their challenges. Furthermore, when societal attitudes towards HIV are negative, individuals may feel less inclined to seek help or disclose their status, further isolating themselves and increasing the risk of self-harm.

Self-esteem showed significant negative prediction on deliberate self-harm among people living with HIV. This finding agrees with Tiamiyu et al. (2024) study which showed that there was significant relationship between self-esteem and self-harm. Similarly, the finding agrees with Kukoyi et al. (2023) study that observed that there was an association between self-esteem, social support, and self-harm but no association between social support and suicide ideation as well as between gender and self-harm. Theoretically, this suggest that some people living with HIV acquired capability is the ability to engage in deliberate self-harm; this involves a decreased fear of death and increased physical pain tolerance which moves some of the people living with HIV from thinking or wanting to engage in deliberate self-harm intentionally because of feeling of their low self-esteem. Perhaps, due to habituation to pain and self-esteem, an individual works up the "courage" or capability to engage in deliberate self-harm (Joiner, 2005).

This finding shows that low self-esteem can exacerbate feelings of hopelessness and despair, making individuals more susceptible to engaging in self-destructive behaviours. For when self-worth is diminished, individuals may feel that they are unworthy of care or support, leading to isolation and an increased risk of deliberate self-harm as a means of expressing emotional pain. More so, those with low self-esteem may struggle to form supportive relationships, further compounding their feelings of loneliness and distress. Moreover, those with low self-esteem may internalize negative societal perceptions of HIV, reinforcing a detrimental cycle that heightens vulnerability to self-harming behaviours.

Perceived discrimination and self-esteem had significant interaction effect on deliberate self-harm among people living with HIV. This is in line with Wang et al. (2021) results that showed that there was a significant positive association among self-esteem, perceived discrimination and NSSI among migrant children. Loneliness and low-esteem mediated the relationship between perceived discrimination and NSSI. Moreover, significant others cohesion demonstrated a moderating effect on the mediation via loneliness; the indirect association among self-esteem, perceived discrimination and NSSI via loneliness was only significant in low significant others cohesion condition, but not in the high condition. Further, the finding is line with Sutin et al. (2018) observations that indicated that low self-esteem and discrimination was associated with increased risk of thoughts of self-harm, hurting the self on purpose, considering suicide, having a suicide plan, attempting suicide, and depressive symptoms. Consequently, these associations generally held adjusting for peer victimization or weight self-perception. In other words, to overcome the victimization that is associated with perceived discrimination one must also overcome the fear that accompanies deliberate self-harm, sometimes through physically hurting oneself (e.g., cutting), practicing a toxic overdose of a drug, practicing tying a noose, or standing on the edge of a bridge (Joiner, 2005).

This joint prediction and interaction suggested that the relationship between perceived discrimination and self-harm is influenced by the level of self-esteem an individual possesses. When individuals experience high levels of perceived discrimination, those with low self-esteem are particularly vulnerable to engaging in self-harm. Due to perceived discrimination can lead to feelings of worthlessness and despair, particularly for those with low self-esteem. These individuals may internalize the stigma associated with HIV, viewing themselves through a negative lens, which exacerbates their emotional pain. As a result, the likelihood of resorting to self-harm increases significantly. Moreover, the interaction effect highlights the complexity of how individual psychological factors intersect with social experiences.

Implications of the Study

Based on the study outcome, healthcare providers, understanding the relationship between perceived discrimination, self-esteem, and self-harm is crucial. With the outcome, healthcare

professionals can better support people living with HIV/AIDS by recognizing the psychological distress linked to low self-esteem and discrimination. This approach can lead to improved patient outcomes and encourage individuals to seek help before resorting to self-harm.

From the study outcome, policy makers can address the systemic issues contributing to perceived discrimination. By implementing policies that promote equality and reduce stigma associated with HIV and mental health, they can create a more inclusive society. Similarly, from the study campaigns aimed at raising awareness about the mental health challenges faced by marginalized people living with HIV/AIDS will be established; this can foster understanding and compassion within communities. Such initiatives can also facilitate access to mental health services, ensuring that individuals receive the support they need.

Psychologists and mental health professionals can utilize the findings to inform their therapeutic practices. Understanding the impact of self-esteem on self-harm can guide interventions aimed at enhancing self-worth and resilience among people living with HIV/AIDS. Since, therapeutic approaches that address the underlying issues of discrimination and self-esteem can be particularly effective in reducing deliberate self-harm.

For the general public, the study will increase awareness of the psychological effects of discrimination and the importance of self-esteem which can foster a more supportive environment for those struggling with deliberate self-harm. This could happen through education campaigns that can challenge stereotypes and promote empathy, encouraging people living with HIV/AIDS to engage in open dialogues about mental health. This shift can lead to greater acceptance and understanding of the complexities surrounding deliberate self-harm.

Following the implications, the study highlights several important recommendations aimed at addressing the significant effects of perceived discrimination and self-esteem on deliberate self-harm.

To effectively address perceived discrimination and low self-esteem among individuals at risk of self-harm, targeted mental health interventions are needed. These interventions should focus on building resilience and self-worth through techniques like cognitive-behavioural therapy (CBT), which helps individuals reframe negative thoughts linked to discrimination.

Additionally, incorporating peer support groups is vital. These groups offer safe spaces for individuals to share their experiences, fostering a sense of belonging and validation that is essential for treatment adherence.

Education and awareness campaigns should also be organized to inform the public about the psychological impacts of discrimination and the importance of self-esteem. By promoting empathy and understanding where communities can create a more supportive environment for those living with HIV/AIDS who struggle with self-harm.

Healthcare providers must receive training on the psychological aspects of discrimination and self-esteem. This training will equip them to identify at-risk individuals and offer appropriate support in a non-judgmental manner, encouraging open discussions about mental health.

Finally, policymakers should implement measures that promote equality and protect the rights of people living with HIV/AIDS. Advocating for anti-discrimination laws and increasing funding for mental health services will help address systemic issues, ultimately reducing discrimination and its detrimental effects on mental health, which can lead to self-harm.

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