

# Effectiveness of Cognitive Behavioral Therapy for Quality of Life among Women with HIV

Mansour Fathi<sup>1</sup>, Leila Abdolmaleki<sup>2</sup>, Sara Makki Alamdari<sup>3</sup>, Seyed Hossein Mohaqeqi Kamal<sup>4\*</sup>

## Abstract

**Objective:** Women living with HIV (WLWH) experience various psychosocial challenges, which negatively affect their quality of life (QOL). The current study examines the outcomes of women living with HIV (WLWH), who receive cognitive behavioral group therapy (CBGT) for improving quality of life in Tehran, Iran.

**Method:** The design of the study is a randomized clinical trial (RCT). Sixty women with HIV were randomly assigned into control and intervention groups, with 30 participants for each group. A 10-session cognitive behavioral group therapy was provided only to the intervention group. The control group participated in 3 sessions without special training. To assess the effectiveness of the intervention, quality of life was measured using the Multidimensional Quality of Life Questionnaire for HIV/AIDS (MQoL-HIV) before and one month after intervention delivery. Pre-test and post-tests were compared using t-test analysis.

**Results:** After 10 weeks of training, the Mean±SD QOL score significantly increased in the intervention group. Based on covariance analysis, the intervention group had a significantly higher QOL score than the control group after the intervention  $P < 0.05$ .

**Conclusion:** Due to the low quality of life among WLWH, CBGT can be helpful in providing psychological rehabilitation to improve the quality of life of this group.

**Keywords:** HIV/AIDS, Group therapy, Cognitive Behavioral Therapy, Quality of life, Women.

## Introduction

Human Immunodeficiency Virus (HIV) continues to bring a serious public health issue in Iran. According to UNAIDS, in 2016, the Islamic Republic of Iran had 5,000 (1,400 - 13,000) new HIV infections and 4,000 (2,500 – 6,200) AIDS-related deaths. There were 66,000 (37,000 – 120,000) people living with HIV, among whom 50% were between the ages of 24 and 35. Compared to the

year 2014, the incidence of women has increased by 41% in Iran (UNAIDS, 2016).

People who live with HIV (PLWH) experience various psychosocial difficulties, including depression, discrimination, stigma, self-blame, job insecurity, housing instability, and social relationship problems (Palwe, Dargar, & Tawri, 2018; Rzeszutek, 2018; Shi et al., 2018), which negatively affect their quality of life (QOL) (Nyamathi et al., 2017; Pinto et al., 2018). The World Health Organization (WHO) defined QOL as “individuals’ perceptions of their position in life in the context of the culture and value systems in which they live and concerning their goals, standards, expectations, and concerns” (WHO, 1998). QOL is important for PLWH, in general, and

1. Associate Professor of social work, Faculty of Social Sciences, Allameh Tabataba'i University, Tehran, Iran

2. M.A in Social work, Faculty of social sciences, Allameh Tabataba'i University, Tehran, Iran.

3. Assistant Professor of social work, West Texas A&M University, USA.

4. Associate Professor of social welfare, Social Welfare Management Research Center, University of Social Welfare and Rehabilitation Science

\*Corresponding Author: Email: hosseinmohaqeq@gmail.

women living with HIV (WLWH), in particular. This group is underserved and has been excluded from HIV interventions for many reasons (Loutfy et al., 2013; Nobakht et al., 2017). Therefore, delivering services to this group is crucial for social workers.

Considering the high prevalence of psychosocial problems among WLWH and its devastating effects, many interventions have been developed and implemented for this group, including medication and psychotherapy. Social work practice with PLWH includes training about HIV/AIDS, advocacy for their rights, providing social support, and training on how to live with HIV (Törrönen, Borodkina, Samoylova, & Heino, 2013). In addition, cognitive behavioral therapy (CBT) has been reported effective among PLWH (Blashill et al., 2017; Caballero-Suárez, Candela Iglesias, Rodríguez Estrada, et al., 2019; Gupta, Durham, & Olowoyeye, 2013; Mehdipour, Rafiepoor, & Hajjalizade, 2019). CBT is a type of therapy that alters an individual's maladaptive thinking and behavior patterns to reduce the maladjustment of moods and behaviors and address psychological problems by increasing PLWH's engagement in the intervention by highlighting clients' strengths, needs, and participation (Constantino, Westra, Antony, & Coyne, 2019; Vujanovic et al., 2017). One of the well-known cognitive-behavioral techniques is the Ellis ABC model, which is also used in the intervention protocol of this study. Albert Alice, an American psychologist in the rational approach and the ABC model, states that it is not external factors or others that upset us but our 'irrational beliefs' that upset us. According to this model, dysfunctional cognitions, emotions, and/or behaviors ultimately stem from our perception of the situation we experience. To be more systematic, according to this theory, an activating event/object (the A in the ABC) will lead to us perceiving that event/object (the B in the ABC) that will determine the internal consequence of the activating event/

object (the C in the ABC) (David, Lynn & Ellis, 2010).

Previous studies have shown that CBT can be effective in improving unhealthy behavior, depression, stress, fatigue, mental health, and anxiety and promoting quality of life (Ayoubi, Bigdeli, & Mashhadi, 2020; Caballero-Suárez et al., 2019; Getu et al., 2021; Han, Hu, Zhu, & Wu, 2020; Li et al., 2022; Pu, Hernandez, Sadeghi, & Cervia, 2020; Saffren et al., 2012; Xiao et al., 2020). Nevertheless, a few studies have focused on the effectiveness of CBT on QOL among WLWH, especially in developing countries (Nyamathi et al., 2017; Palwe et al., 2018).

Some studies conducted in Iran show that these people have little support. The lack of information and research on the quality of life and support for people with HIV has been fueled by a lack of knowledge from policymakers in this area. Carrying out research on these issues and addressing the problems and concerns of these patients can be a step forward and a beginning to change the attitude towards AIDS and attention to those suffering from it.

In this study, the researchers developed a cognitive behavioral group therapy (CBGT) intervention and implemented it among a group of WLWH in Tehran to improve their QOL. The current study examined this intervention's effectiveness in terms of QOL.

### **Participants and Procedure**

The present research is an experimental study with a pre-test-post-test design and a control group. Participants filled out the quality of life questionnaire once before the implementation of the intervention and later one month after its termination.

Participants were all WLWH, recruited from the Society for the Revival of Values in Tehran, Iran. It is a non-governmental organization founded in Tehran in 1999. The goal of this association is to achieve new ways of preventing

and intervening in times of crisis and managing social issues. Common services of the association include holding seminars on HIV prevention and information, empowerment and vocational training of women heads of households living with HIV, free telephone counseling, and social work services and counseling.

Recruitment happened from May to September 2020. The researcher was a master's level student in social work and had received the necessary training for implementing the intervention. After obtaining the required permission from the Society

for the Revival of Values, each participant was called by phone. After explaining the objectives and obtaining oral consent, the person was invited to complete a multidimensional QOL questionnaire. Hundred-twenty-one clients of the center who live with HIV/AIDS volunteered to complete the questionnaire. Sixty of them with the lowest score were selected for the study. Other inclusion criteria were being married, being able to read and write at least, and having passed at least three months since HIV diagnosis. Those with advanced stages of the disease and who were absent for more than

**Table1.** Intervention – CBGT protocol

| Module no. | No. of sessions | Topic                   | Content   |
|------------|-----------------|-------------------------|---|
| 1          | one             | Adherence training      | Creating a positive and supportive relationship with the peers and the social worker<br>Introducing the rules and objectives of the protocol  |
| 2          | two             | Cognitive restructuring | Learning about irrational beliefs and cognitive errors including:<br>·Mind reading<br>·Personalization<br>·Magnification<br>·Black & white thinking<br>·Baseless inferences   |
| 3          | three           | Cognitive coping        | Practicing positive self-talk technique when faced with problems<br>Enhancing communication skills through utilizing messages and empathic listening  |
| 4          | two             | Behavioral activation   | Courage training, through role-playing and assignment<br>Interviewing participants about daily routine<br>Improving communication skills<br>Teaching safe lovemaking and intimacy in marital relationships through practice of healthy interactions, empathy, clarification of intimacy defects |
| 5          | one             | Problem solving         | Identifying and defining problem<br>Brainstorming to create potential solutions<br>Evaluating the potential solutions<br>Decision making<br>Implementing the chosen solution  |
| 6          | one             | Relaxation training     | Stress reduction training, and practicing self-relaxation techniques through<br>·Progressive muscle relaxation<br>·Diaphragmatic breathing  |

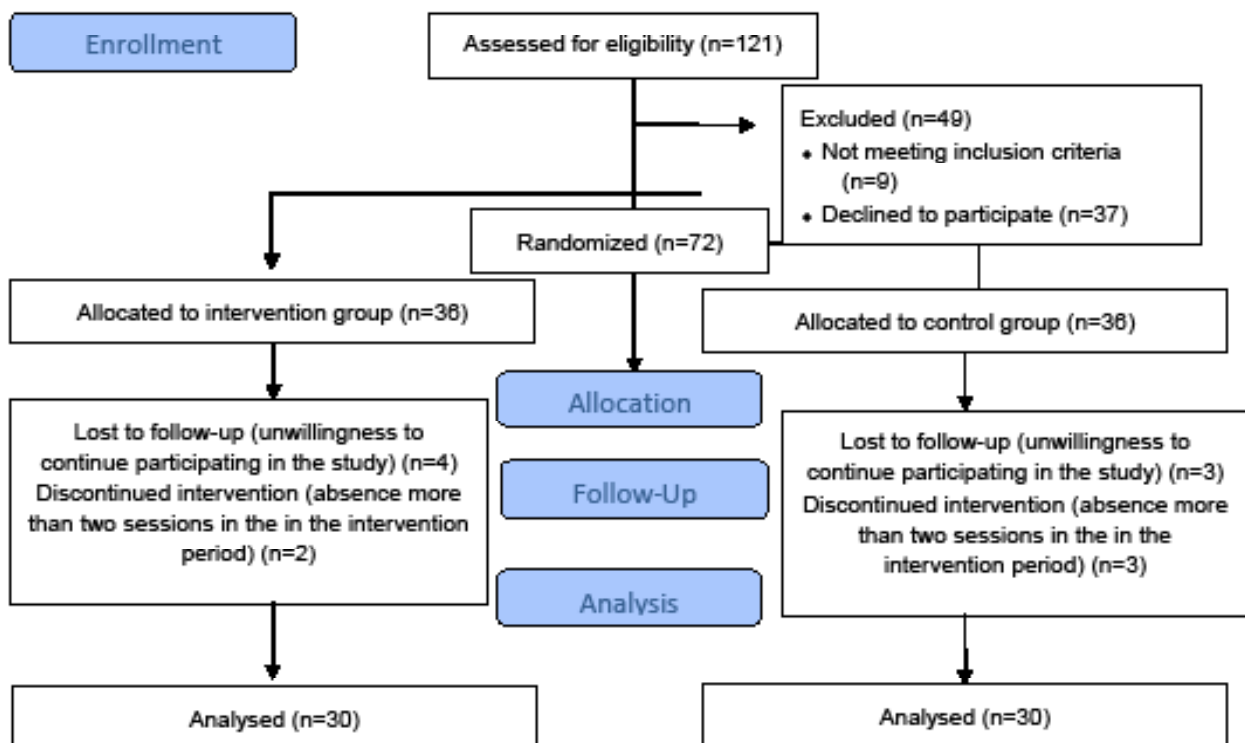
two sessions were exclusion criteria of the study. Out of 121 people who completed the quality of life questionnaire, 60 who received lower scores were selected and randomly divided into two groups (experimental and control). Before the implementation of the intervention, written consent was obtained from each person.

### Ethical statement

According to this protocol, participation in this study was completely voluntary. Further, they were informed that all collected data would be confidential, without any identifying information, and the gathered data would be kept in locked drivers so only researchers have access. Informed consent forms were also provided for participants, and their signatures were obtained before participation. Finally, to ensure ethical consideration, the control group received the same intervention after the end of this study.

### Intervention

The intervention was ten weekly sessions of counseling with a CBT approach – based on the ABC model- in a group setting with an emphasis on QOL. The intervention lasted ten sessions for 2.5 months. A 90-minute session was held each week. The contents of the sessions were verified by faculty members from different disciplines, including Social work, Psychiatry, and Clinical Psychology at Allameh Tabataba'i University. Details of the protocol are summarized in Table 1. The questionnaire in this study had two parts: the first part included socio-demographic characteristics, including age, educational level, employment status, and cause of infection. The second part was the Iranian version of the Multidimensional Quality of Life Questionnaire for HIV/AIDS (MQoL-HIV) (Kemmler et al., 2003; Smith, Avis, Mayer, & Swislow, 1997). MQoL-HIV is a 31-item self-report questionnaire with five dimensions of mental health, physical functioning,



**Figure1. Consolidated Standards of Reporting Trials (CONSORT) flow diagram of study**

interpersonal relationships, cognitive functioning, and relationship with spouse. The validity of the questionnaire was approved through face validity, and its reliability was verified through internal consistency. The internal reliability coefficient of the subscales (using Cronbach's alpha coefficient) was 0/88, the highest value of which is related to

and post-test as well as intervention and control groups. In all tests, a P-value of  $\leq 0.05$  was reported significant.

## Results

The average age of participants in the intervention group was  $40.01 \pm 5.71$  years, and the control group

**Table2. Demographic characteristics in both intervention and control groups**

| Groups           | Control<br>n=30 (%) | Intervention<br>n=30 (%) | Chi Square test<br>Value (p-value) |
|------------------|---------------------|--------------------------|------------------------------------|
|                  | Age (year)          |                          | 6.20 (0.29)                        |
| 20-30            | 5                   | 6                        |                                    |
| 30-40            | 13                  | 12                       |                                    |
| $\geq 40$        | 12                  | 12                       |                                    |
|                  | Educational level   |                          | 4 (0.55)                           |
| Primary school   | 12                  | 9                        |                                    |
| Secondary school | 7                   | 7                        |                                    |
| High school      | 11                  | 14                       |                                    |
|                  | Employment status   |                          | 1.33 (0.72)                        |
| Employee         | 12                  | 16                       |                                    |
| Unemployed       | 18                  | 14                       |                                    |
|                  | Cause of infection  |                          | 6 (0.11)                           |
| Sexual contact   | 21                  | 18                       |                                    |
| Shared syringe   | 9                   | 12                       |                                    |

the interpersonal relationship sub-scale with 93% and the lowest of which is to the cognitive function subscale with 71% (Orzolla & Moradi, 2006; Rasafiani et al., 2020; Sanagouye Moharer, Raisi, & Sultan Ahmadi Moghaddam, 2018). The scoring is based on a 5-point Likert scale with options from low (code 1) to high QOL (code=5).

Figure1. Consolidated Standards of Reporting Trials (CONSORT) flow diagram of study

### Data analysis

Descriptive statistics, including mean, standard deviation (SD), and frequency, were provided for all variables. ANCOVA was used to compare pre

was  $38.59 \pm 5.82$ . Regarding employment status, 55% of the intervention group and 40% of the control group were employed. All women had part-time jobs such as packaging and cleaning services. The women under study have been covered by the association for six months to 5 years. Also, the range of participants' responses about the duration of the disease was between 9 months to 7 years. There were no significant differences between the two groups concerning age, educational level, employment status, and cause of infection.

There is a difference between the two groups in terms of QOL after the intervention (Table 3). After the intervention, QOL in the intervention group

(M=103.95) is higher than in the control group (M=50.45).

**Table 3.** QOL scores in the intervention and the control group

| Groups       | Stages    | Mean   | SD    |
|--------------|-----------|--------|-------|
| Intervention | Pre-test  | 56.41  | 12.91 |
|              | Post-test | 103.95 | 12.78 |
| Control      | Pre-test  | 53.50  | 11.98 |
|              | Post-test | 50.45  | 10.16 |

To check the statistical significance of this difference, ANCOVA was employed. Assumptions were checked. The result of the Kolmogorov-Smirnov test was not significant ( $P > 0.05$ ), which shows the data is distributed normally. The results of Leven's analysis were not meaningful ( $F(1) = 2.34, P > 0.05$ ). Then homogeneity of variance is confirmed. Also, the assumption of homogeneity of regression slopes was confirmed for relationships

between QOL and pre-test ( $F(1) = 4.15, P > 0.05$ ). Based on covariance analysis, the intervention group had a significantly higher QOL score than the control group after the intervention ( $F(1) = 4.75, P < 0.05$ ) (Table 4). So, the hypothesis was confirmed with a 39% effect size, demonstrating that 39% of score changes in the QOL are related to CBT intervention.

### Discussion and conclusion

WLWH are among the most vulnerable social groups who need the social work profession's service and advocacy. This group faces many problems and obstacles in their individual, family, and social life affecting their well-being, self-efficacy, mental health, and quality of life (Törrönen et al., 2013). Therefore, improving their quality of life through social services is imperative for social workers. The findings indicated a significant difference

**Table 4.** Comparison QOL and its subscales in both intervention and control groups

| QOL                         | Groups       | Before        | After 1 month   | After 3 months  | P value          | P value          |
|-----------------------------|--------------|---------------|-----------------|-----------------|------------------|------------------|
|                             |              | intervention  | of intervention | of intervention | (between         | (between         |
|                             |              | Mean ± SD     | Mean ± SD       | Mean ± SD       | before and       | one and          |
|                             |              |               |                 |                 | 1 month)         | 3 month)         |
| Mental health               | Intervention | 8.20 ± 3.15   | 11.90 ± 2.55    | 12.81 ± 2.16    | $p < 0.001^{**}$ | 0.01**           |
|                             | Control      | 7.15 ± 1.81   | 6.60 ± 1.88     | 6.99 ± 1.87     | 0.18**           | 0.48**           |
|                             | -            | * $p = 0.34$  | * $p = 0.02$    | * $p = 0.03$    | -                | -                |
| Physical function           | Intervention | 13.10 ± 5.81  | 24.90 ± 4.53    | 22.82 ± 4.56    | 0.01**           | 0.02**           |
|                             | Control      | 13.05 ± 4.22  | 11.65 ± 2.48    | 12.05 ± 1.54    | 0.78**           | 0.22**           |
|                             | -            | * $p = 0.54$  | * $p < 0.001$   | * $p < 0.001$   | -                | -                |
| Interpersonal relationships | Intervention | 12.70 ± 5.32  | 25.15 ± 2.83    | 24.85 ± 2.77    | $p < 0.001^{**}$ | $p < 0.001^{**}$ |
|                             | Control      | 12.35 ± 2.75  | 11.95 ± 2.67    | 13.55 ± 2.31    | 0.89**           | 0.20**           |
|                             | -            | * $p = 0.67$  | * $p < 0.001$   | * $p < 0.001$   | -                | -                |
| Cognitive function          | Intervention | 7.00 ± 1.95   | 14.30 ± 2.34    | 15.40 ± 2.74    | $p < 0.001^{**}$ | 0.01**           |
|                             | Control      | 7.75 ± 3.16   | 6.90 ± 2.29     | 7.35 ± 2.48     | 0.44**           | 0.23**           |
|                             | -            | * $p = 0.88$  | * $p < 0.001$   | * $p = 0.00$    | -                | -                |
| Relationship with spouse    | Intervention | 14.65 ± 5.74  | 27.70 ± 3.42    | 26.45 ± 4.72    | 0.02**           | 0.04**           |
|                             | Control      | 13.95 ± 4.65  | 13.35 ± 4.56    | 13.20 ± 3.51    | 0.62**           | 0.14**           |
|                             | -            | * $p = 0.59$  | * $p = 0.02$    | * $p = 0.02$    | -                | -                |
| Total score of QOL          | Intervention | 56.41 ± 20.91 | 103.95 ± 12.78  | 102.30 ± 11.15  | $p < 0.001^{**}$ | $p < 0.001^{**}$ |
|                             | Control      | 53.50 ± 11.98 | 50.45 ± 10.16   | 53.10 ± 7.73    | 0.59**           | 0.17**           |
|                             | -            | 0.67          | * $p < 0.001$   | * $p < 0.001$   | -                | -                |

\*Independent-samples t-test, \*\* Paired-samples t-test

**Table 5.** Covariance analysis

| Variable        | Source  | Sum of squares | df | Mean square | F    | P     | Partial Eta Squared |
|-----------------|---------|----------------|----|-------------|------|-------|---------------------|
| Quality of life | Pretest | 1129.96        | 1  | 1129.96     | 5.73 | 0.022 | 0.47                |
|                 | Group   | 936.73         | 1  | 936.73      | 4.75 | 0.036 | 0.39                |
|                 | Error   | 312.24         | 38 | 8.21        |      |       |                     |
|                 | Total   | 2378.93        | 41 |             |      |       |                     |

between the control and intervention groups in QOL after the CBGT intervention; therefore, the main hypothesis of the study is confirmed. CBGT was found to be an effective intervention in improving self-motivation, mental health, coping with mental conflicts, personal and social capacity, and social participation among WLWH.

The findings of this study are consistent with several studies (Gupta et al., 2013; Kahrazei, Danesh, & Azadfallah, 2011). They found that CBT intervention improves the QOL among chronic patients. For example, Kahrazei et al. (2011) showed that CBT intervention could promote the quality of life of cancer patients. The results of other studies also showed that this intervention improves the participants' physical activity (Cosio, Jin, Siddique, & Mohr, 2011; Tsiros et al., 2008).

In line with Ellis's cognitive theory, emotional reactions and lifestyles are related to basic beliefs. CBT helps people enhance their QOL by identifying and challenging irrational ideas and practicing rational beliefs (Cary & McMillen, 2012). It also can help individuals develop problem-solving skills and achieve insight and capacity to change their lifestyles. In addition, it causes WLWH to get the knowledge and skills necessary for better interpersonal relationships, mental status, physical functioning, and spousal relationships. All this ultimately leads to better QOL.

All in all, according to the results of these findings, it can be said that women living with HIV face many problems: cognitive problems, social exclusion, and lack of understanding by others, as well as social and cultural problems. In addition to these issues, also due to this particular disease,

psychological and social pressure is added to their physical disorders, and in general, it can be said that they are apprehensive about those who report HIV to those around them. This, in turn, distances them from others and relatives and, as a result, reduces their social support. One of the significant factors in these women is paying attention to the quality of life and its life characteristics. In the present study, group intervention with a cognitive-behavioral approach has been used to improve it.

Recommendations of this study to social workers include:

- Providing individual and group counseling and CBT sessions to help PLWH accept the disease, encourage them to engage in the treatment, and create hope for them.
- Delivering trainings around life skills (e.g., problem solving skills and coping strategies) to PLWH.

This study was limited to WLWH in Tehran, and hence its generalizability to other PLWHs, including men or women in other cities of Iran, is not possible. For future studies, it is recommended to examine other groups of PLWH in this country. In addition, the data in this study were self-reported, which might cause social desirability bias. To minimize biases, the researchers explained the intervention plan, its goals, benefits, and drawbacks to participants once they became involved in the study. In addition, due to time constraints, the follow-up stage was performed one month after the intervention.

### Conclusions

According to the results of this study, cognitive

behavioral group therapy (CBGT) enhanced the QOL of WLWH in Tehran, which should be considered a necessary intervention by social workers when working with WLWH.

### Funding

This research did not receive any grant from funding agencies in the public, commercial, or non-profit sectors.

### Acknowledgements

Authors appreciate those who participated in this study.

### Conflict of interest

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## References

- Ayoubi, J., Bigdeli, I., & Mashhadi, A. J. Q. J. O. H. (2020). The effect of Mindfulness-integrated Cognitive Behavior Therapy on quality of life, psychological distress and adherence in patients with type 2 Diabetes Mellitus. *9(34)*, 75-94.
- Blashill, A. J., Safren, S. A., Wilhelm, S., Jampel, J., Taylor, S. W., O'Cleirigh, C., & Mayer, K. H. (2017). Cognitive behavioral therapy for body image and self-care (CBT-BISC) in sexual minority men living with HIV: A randomized controlled trial. *Health Psychology, 36(10)*, 937-946. doi:10.1037/hea0000505
- Caballero-Suárez, N. P., Candela Iglesias, M., Rodríguez Estrada, E., Reyes Terán, G., & Riveros Rosas, A. (2019). Effects of cognitive-behavioural therapy on anxiety, depression and condom use in people with HIV in Mexico City: a pilot study. *Psychology, Health and Medicine, 24(1)*, 115-125. doi:10.1080/13548506.2018.1503694
- Cary, C. E., & McMillen, J. C. (2012). The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. *Children and Youth Services Review, 34(4)*, 748-757. doi:<https://doi.org/10.1016/j.childyouth.2012.01.003>
- Constantino, M. J., Westra, H. A., Antony, M. M., & Coyne, A. E. (2019). Specific and common processes as mediators of the long-term effects of cognitive-behavioral therapy integrated with motivational interviewing for generalized anxiety disorder. *Psychotherapy Research, 29(2)*, 213-225. doi:10.1080/10503307.2017.1332794
- Cosio, D., Jin, L., Siddique, J., & Mohr, D. C. (2011). The effect of telephone-administered cognitive-behavioral therapy on quality of life among patients with multiple sclerosis. *Annals of behavioral medicine : a publication of the Society of Behavioral Medicine, 41(2)*, 227-234. doi:10.1007/s12160-010-9236-y
- David, D., Lynn, S. J., & Ellis, A. (2010). *Rational and irrational beliefs: Research, theory, and clinical practice*: Oxford University Press.
- Getu, M. A., Chen, C., Panpan, W., Mboineki, J. F., Dhakal, K., & Du, R. J. Q. o. L. R. (2021). The effect of cognitive behavioral therapy on the quality of life of breast cancer patients: a systematic review and meta-analysis of randomized controlled trials. *30(2)*, 367-384.
- Gupta, A., Durham, R., & Olowoyeye, A. (2013). Cognitive Behavioural Therapy (CBT) for adults with HIV. *Cochrane Database of Systematic Reviews, 2013(10)*. doi:10.1002/14651858.CD006494.pub2
- Han, S., Hu, Y., Zhu, Z., & Wu, B. (2020). Dataset of cognitive behavioral intervention for persons living with HIV in China: A randomized pilot trial. *Data in Brief, 30*. doi:10.1016/j.dib.2020.105459
- Kahrazei, F., Danesh, E., & Azadfallah, P. (2011). Effectiveness of Cognitive-Behavioral Therapy on improving quality of life of cancer patients. *Journal of Applied Psychology, 18(5)*, 7-23.
- Kemmler, G., Schmied, B., Shetty-Lee, A., Zangerle, R., Hinterhuber, H., Schüssler, G., & Mumelter, B. (2003). Quality of life of HIV-infected patients: Psychometric properties and validation of the German version of the MQOL-HIV. *Quality of Life Research, 12(8)*, 1037-1050. doi:10.1023/a:1026114004548
- Li, X., Laplante, D. P., Paquin, V., Lafortune, S., Elgbeili, G., & King, S. J. C. P. R. (2022). Effectiveness of cognitive behavioral therapy for perinatal maternal depression, anxiety and stress: A systematic review



- and meta-analysis of randomized controlled trials. *92*, 102129.
- Loutfy, M. R., Sherr, L., Sonnenberg-Schwan, U., Walmsley, S. L., Johnson, M., d'Arminio Monforte, A., & Women for Positive, A. (2013). Caring for women living with HIV: gaps in the evidence. *Journal of the International AIDS Society*, *16*(1), 18509-18509. doi:10.7448/IAS.16.1.18509
- Mehdipour, F., Rafiepoor, A., & Hajjalizade, K. J. I. J. o. H. P. (2019). The Effectiveness of Mindfulness-Based Cognitive Group Therapy (MBCT) In Improving Quality of Life Among Patients with Cancer. *2*(1), 125-134.
- Nobakht, A., Mohraz, M., Rahimzadeh, M., Tehranizadeh, M., Bayat-Jozani, Z., & Esmaelzadeh, S. (2017). The effect of cognitive-behavioural therapy on the reproductive health of women with HIV: a randomised controlled trial. *HIV & AIDS Review. International Journal of HIV-Related Problems*, *16*(4), 236-243. doi:10.5114/hivar.2017.71911
- Nyamathi, A. M., Ekstrand, M., Yadav, K., Ramakrishna, P., Heylen, E., Carpenter, C., . . . Sinha, S. (2017). Quality of Life Among Women Living With HIV in Rural India. *J Assoc Nurses AIDS Care*, *28*(4), 575-586. doi:10.1016/j.jana.2017.03.004
- Orzolla, V., & Moradi, S. (2006). Evaluation of quality of life and its related factors in women with AIDS in Tehran. *Journal of Family Research*, *2*(8).
- Palwe, S. D., Dargar, S., & Tawri, P. S. (2018). Assessment of quality of life and its associated factors among people living with HIV/AIDS. *HIV & AIDS Review. International Journal of HIV-Related Problems*, *17*(2), 134-141. doi:10.5114/hivar.2018.76371
- Pinto, R. M., Spector, A. Y., Witte, S. S., Filippone, P., Choi, C. J., & Wall, M. (2018). Training in Evidence-Based Practices Increases Likelihood to Integrate Different HIV Prevention Services with Substance-Using Clients. *Social work in public health*, *33*(3), 202-214. doi:10.1080/19371918.2018.1438326
- Pu, H., Hernandez, T., Sadeghi, J., & Cervia, J. S. (2020). Systematic review of cognitive behavior therapy to improve mental health of women living with HIV. *Journal of Investigative Medicine*, *68*(1), 30-36. doi:10.1136/jim-2019-000996
- Rasafiani, M., Sahaf, R., Shams, A., Vameghi, R., Zareian, H., & Akrami, R. J. I. J. o. A. (2020). Validity and reliability of the persian version of the world health organization quality of life questionnaire—the older adults edition. *15*(1), 28-41.
- Rzeszutek, M. (2018). Health-related quality of life and coping strategies among people living with HIV: the moderating role of gender. *Arch Womens Ment Health*, *21*(3), 247-257. doi:10.1007/s00737-017-0801-2
- Safren, S. A., O'Cleirigh, C. M., Bullis, J. R., Otto, M. W., Stein, M. D., & Pollack, M. H. (2012). Cognitive behavioral therapy for adherence and depression (CBT-AD) in HIV-infected injection drug users: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *80*(3), 404-415. doi:10.1037/a0028208
- Sanagouye Moharer, G., Raisi, M., & Sultan Ahmadi Moghaddam, F. (2018). Relationship between Religious Coping Styles and Quality of Life in HIV-Positive Patients. *Religion and Health*, *5*(2), 58-67.
- Shi, Y., Zhao, M., Chen, S., Wang, S., Li, H., Ying, J., . . . Sun, J. (2018). Effects of cognitive behavioral therapy on people living with HIV and depression: A systematic review and meta-analysis. *Psychol Health Med*, 1-17. doi:10.1080/13548506.2018.1549739
- Smith, K. W., Avis, N. E., Mayer, K. H., & Swislow, L. (1997). Use of the MQoL-HIV with asymptomatic HIV-positive patients. *Qual Life Res*, *6*(6), 555-560.
- Törrönen, M., Borodkina, O., Samoylova, V., & Heino, E. (2013). *Empowering Social work: research and practice*: University of Helsinki, Kotka Unit Kopijyvä Oy.
- Tsiros, M. D., Sinn, N., Brennan, L., Coates, A. M., Walkley, J. W., Petkov, J., . . . Buckley, J. D. (2008). Cognitive behavioral therapy improves diet and body composition in overweight and obese adolescents. *Am J Clin Nutr*, *87*(5), 1134-1140. doi:10.1093/ajcn/87.5.1134
- UNAIDS. (2016). UNAIDS, Islamic Republic of Iran. Retrieved from <http://www.unaids.org/en/regionscountries/countries/islamicropublicofiran>
- Vujanovic, A. A., Meyer, T. D., Heads, A. M., Stotts, A. L., Villarreal, Y. R., & Schmitz, J. M. (2017).

- Cognitive-behavioral therapies for depression and substance use disorders: An overview of traditional, third-wave, and transdiagnostic approaches. *American Journal of Drug and Alcohol Abuse*, 43(4), 402-415. doi:10.1080/00952990.2016.1199697
- WHO. (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. The WHOQOL Group. *Psychol Med*, 28(3), 551-558.
- Xiao, X., Reynolds, N. R., Saligan, L., Lei, Y., Wang, M., & Wang, H. (2020). Effectiveness of non-pharmacological interventions to decrease fatigue in people living with HIV/AIDS: A protocol of systematic review and meta-analysis. *BMJ Open*, 10(9). doi:10.1136/bmjopen-2020-040996



#### COPYRIGHTS

© 2022 by the authors. Licensee PNU, Tehran, Iran. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution 4.0 International (CC BY4.0) (<http://creativecommons.org/licenses/by/4.0>)