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HIV/AIDS, Choice of Coping Strategies: Implications for Gender Role Differences

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Abstract: The study investigated the role of gender in the choice of coping strategies for HIV/AIDS. 60 clients made up of 30 males and 30 females drawn from Sani Abatcha Specialist Hospital Damaturu, served as participants. It was proposed that more male would use problem focused coping than their female counterparts, while more of the females would use emotion focused coping than the males. The results did not support the study question for the males problem coping (X^2 (1, 60) = 3.48, $p < 0.05$), but it supports the gender differences for the emotion focused coping for the females (X^2 (1,60) = 7.5002, $p < 0.05$). The implication of this finding is that clinicians have to be dynamic and proactive in their attempts to help the HIV/AIDS patients develop healthy coping strategies.
Keywords: HIV/AIDS, Coping Strategies, Gender, Differences

INTRODUCTION

Human beings are generally responsive to forces that threaten their existence. Threatening situations are often accompanied by unpleasant emotions called anxiety. These anxieties are caused by stressful situations which in turn lead to depression depending on the intensity or severity. The threats range from daily life stressors to those that threaten existence.

The goal of human existence is to be happy and be free from pain. Anything that hinders the achievement of this goal is usually dealt with. To deal with such threat therefore, humans employ different strategies to ensure the attainment of the goal. Coping is the name given to the strategies used to ensure that goals are achieved. Coping can be defined as any action taken by individuals to reduce the effect of stress on them and/or escape from their adversity.

Similarly, Pearlin and Aneshensel defined coping as the things people do to avoid or minimize the stress that would otherwise result from problematic conditions of life[1]. They also explained that coping involves both having resources and using various coping strategies. By coping resources they mean those psychological and material assets available to individuals and their families in responding to stressful events.

Coping resources at individual level include; one's education, income, self esteem, sense of mastery, and psychological hardiness. Family resources include; integration (having strong ties of affection, pride in family tradition, and history of sharing in activities) and adaptability (having flexible social roles, sharing responsibilities and open communication).

Top on the list of such stressful conditions is any terminal disease. When an individual is diagnosed with a terminal disease, and the fact that death is inevitable any moment, it creates a sense of fear. Of recent, one of such dreadful terminal diseases is HIV/AIDS. Often when individuals are diagnosed HIV positive, they make frantic attempts to deny the reality at first and then employ different strategies to deal with it. HIV is the acronym for Human Immuno-Deficiency Virus, while AIDS stands for Acquired Immune Deficiency Syndrome. HIV is the infection with the virus. AIDS is the disease resulting from infection with the virus.

Until date, AIDS does not have a cure. This makes it one of the terminal diseases of the 20th Century. The first case was reported in 1981. With reference to Sani Abatcha Specialist Hospital, Damaturu, Yobe State, the first case was reported in 1990.

This study anticipates that the coping strategies for HIV/AIDS might differ according to gender. Conceptually psychodynamic theories refer to faulty coping strategies as defense mechanisms. Commonly used defense mechanism by HIV positive individuals is denial. It has not been established as to whether such

strategies are affected by gender or not. This particular need prompted this study.

Coping strategies could be classified as normative or functional. Normative coping refers to the coping behaviour that is learned and shared by a reference group. Functional coping however involves the following problem solving functions namely; the modification of the meaning of the condition in such a way that threat is reduced and the modification of situations that aggravate stressful problems and the creative management of symptoms.

From practical perspective, coping strategies could be categorized as:

Emotion-Focused Coping

This involves mood alleviation by sharing activities when there is nothing that can be done about the stress or when tangible resources are not adequate for confronting the stressful situations but which suit ego bolstering feelings and psychological soothing.

Behavioural Coping

This strategy involves participating in recreational activities like social functions, reading, attending parties, games etc. to undo the effect of the stress or as a deviational therapy.

Cognitive Appraisal

This strategy involves changing the meaning of the stressful situation in order to remain emotionally calm or maintain psychological stamina.

Problem-Focused Coping

This strategy is employed to reduce the demands of stress. The individual makes use of resources available to him to tackle specific problems or situations etc. One such resource that may be employed is ego defense mechanism. In this sense, ego defense mechanisms are regarded as coping styles. It is pertinent to note that ego defense mechanisms are not always detrimental to the individual but it can also aid the adjustment process.

Literatures in this area of systematic study of coping strategies for the chronically ill are few. Dunkel et al made use of systematic coping strategies on cancer patients[2]. The method involved social support/direct problem solving, Distancing, Positive focus Cognitive/Avoidance. Taylor et al found that those who employed multiple strategies cope better with stress induced chronic or terminal disease than those that engaged in predominant coping style[3].

It is evident from literature that effective coping to some extent depends on the following; the beliefs about the controllability of illness-results show that patients that have the feelings of control were highly successful in promoting good adjustment and reduction of psychological and emotional distress caused by illness [3, 2]; gender differences[4]. It is proposed that females have better survival prospect for chronic illness, while Stroebe & Stroebe found males to be highly susceptible to negative stressors[5].

In relation to HIV/AIDS, Hayder investigated the role of gender in the experiences of young children in Namibia[6]. They found gender to shape schooling-age girls and boys experiences of being infected or affected by HIV/AIDS in many African nations. Another study by Rompel and Gronemeyer found no gender differences in the rate of infection with HIV/AIDS, but differences in the opinions to react to challenges presented by the infection [7]. Brown and Lewis assess coping strategies of female adolescents infected with HIV/AIDS and found listening to music, thinking about good things, making own decisions and being closed to someone as the most utilized coping strategies[8].

Epidemiology of HIV/AIDS by USAID reveals that 46% of adults living with HIV worldwide are women. 57% adolescents' girls faced high risk in sub-saharan Africa. Girls between ages 15 – 19 indicated a higher rate 3 – 6 times higher than boys of the same range [9]. Similarly, Fleishman reported that in some countries in South Africa, HIV prevalence among girls aged 15 – 19 is four times to seven times higher than among boys their age [10].

In summary, there is evidence of gender differences in the etiology and coping styles of HIV/AIDS. The common coping strategies mentioned above are not necessarily the ones adopted most times to cope with HIV/AIDS.

This study therefore investigates the role gender might play in coping with the infection. It is also aimed at identifying the various coping strategies adopted by victims. To this effect the following questions are raised:

- To what extent is coping with HIV/AIDS a gender issue?
- Which of the coping strategies are employed by males and those employed by females?
- What is the relationship between chosen coping strategies and the prevalence of the infection?

To answer these questions, this study explained the following hypotheses;

1. Males are likely to adopt problem-focus coping strategies than their female counterparts.
2. Females are more likely to adopt emotionally-focused coping strategies than the males.

METHOD

Participants

The participants for the study were 60 HIV positive patients. 30 of them were females and 30 males. They were volunteers either undergoing treatment or counseling at the Sani Abatcha Specialist Hospital Damaturu. Their ages range from 20 – 45 years with a mean of 33.5 and a standard deviation of 6.34. 15 (25%) were single. 10 (16.67%) were married, 10 (16.67%) were either divorced or separated, and 25 (14.66%) were either widows or widowers. 15 (25%) were primary school leavers, 22 (36.67%) had secondary education, 20 (33.33%) had post secondary education and 3 (5%) had tertiary education.

Instrument

The instrument used for collecting the data was a 20 items questionnaire consisting of two sections. The first set of 10 items assessed problem-focused coping strategy, while the second set of 10 items assessed emotion-focused coping strategy. The response was a yes or no option.

Design

Two factors were assessed (gender and coping strategy). Gender has two levels (male x females). Coping strategy also has two levels (problem-focused x emotion-focused). Since the data was nominal in nature X^2 was used to analyze the results.

Procedure

Since the participants were a special group, two research assistants from HIV/AIDS Counseling unit were used to administer the questionnaires. The assistants were allowed to help participants that could not read and write fill the questionnaires. The data were collected over two weeks. Application was required by the Principal Medical Officer (PMO) followed by interview.

RESULTS

A vivid description of the results of this study is presented below. Frequency distribution was used to organize the descriptive statistics, while X^2 was used for the inferential analysis.

Table 1 : Frequency Distribution of Age

Age Range	Frequency	Percentage
20 - 24	**6**	**10**
25 - 29	**8**	**13.33**
30 - 34	**21**	**35**
35 - 39	**15**	**25**
40 - 44	**7**	**11.67**
45 - 49	**3**	**5**

From table 1 above, the highest frequency of the age distribution of the Participants is from 30 – 39. This particular age is the most vulnerable age for HIV/AIDS infection. It is the most active years for sexual exploitation.

Table 2: Chi – square Contingency table for Problem focused coping

Gender	Yes	No
Male	31 **39.5**	29 **30.5**
Female	28 **29.5**	32 **30.5**

*Observed frequency-normal type *Expected frequency- bold type

The results for problem – focused coping style (table 2) was not statistically significant X^2 (1.60) = 3.48, $p < 0.05$). This indicates that gender difference does not exist for problem-focused coping.

Table 3: Chi-square contingency table for emotion-focused coping

Gender	Yes	No
Male	23 **30.5**	37 **29.5**
Female	38 **30.5**	22 **29.5**

*Observed frequency – normal type *Expected frequency – bold type

The results for emotion-focused coping (table 3) was statistically significant (X^2 (1, 60) = 7.5002, $P<0.05$). This results shows that gender difference exist for emotion-focused coping.

DISCUSSION

A very high frequency of participants aged 30-39 years is a further confirmation of many studies which found this age to constitute the risk group. This age range corresponds to active years of sexual exploitation. This has implication for the coping strategies that are usually employed by those suffering from HIV/AIDS. Young people are most likely to employ more pathological coping strategies because of the stigma associated with HIV/AIDS

The results of the study did not support the hypothesis that male participants would likely employ problem-focused coping more than their female counterparts. This finding was consistent with that found by Nerenz and Leventhal [11]. They posited that belief about the nature of illness particularly chronic illness affect adjustment. Problem-focused coping makes use of resources available to cope. One commonly used coping resources by males and females are defense mechanism. This could be part of the reason why there is no gender differences in the use of problem-focused coping.

The results of the study however supported gender differences in the use of emotion-focused coping. Higher number of females indicated the use of emotion-focused coping strategy. This finding is also consistent to those found by Deridder [12] and Antonucci [13] that women are more emotionally oriented including the strategy for coping with HIV/AIDS. Socio-cultural theories also explain that females are socialized to openly express their emotions while males are not. This explains why females would adopt this strategy more than their male counterparts.

It is probably correct to suggest that a gender difference does not exist for problem-focused coping because there is a recent change in female socialization. Females are currently being socialized to be more problem-focused just as their male counterparts.

The implication of this finding is that clinicians have to be dynamic and proactive in their attempts to help the HIV/AIDS patients develop healthy coping strategies.

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