

CHAPTER ONE



INTRODUCTION

1.1 HIV/AIDS in context

The HIV/AIDS epidemic affects the world in various ways that may still be difficult to imagine. Across the globe, the cause and effect of HIV-infection are linked in a deadly dance. The most vulnerable to the virus are the poor, who are vulnerable to its socio-economic impacts and the least affected by national education campaigns (Jackson, Kerkhoven, Lindsey, Mutangadura & Nhara (2000).

Dorrington, Bourne, Bradshaw, Laubscher and Timaeus (2001) estimate that by the year 2010 there could be as many as five to seven million cumulative AIDS deaths in South Africa. It has also been estimated that there are currently around 800 000 children in South Africa under the age of 18 who have lost a mother the majority to AIDS (Children's institute of the University of Cape Town, 2002). This figure is expected to rise dramatically and peak around 2015 with as many as three million children having no living mother. The number of children having lost one or both parents is predicted to be 5.7 million (Johnson & Dorrington, 2001).

The fact that there will be significant mental health consequences arising from the pandemic is hardly debatable. In sub-Saharan Africa, 55% of HIV-positive adults are

women. In South Africa twice as many women between the ages of 15 and 24 are HIV-positive than men in the same age group (Walker, Reid & Cornell, 2004). And in South Africa as a whole twelve to thirteen women are currently infected for every ten men. How can this be explained? In order to understand the AIDS epidemic it is crucial that it should be viewed in its social context and power dynamics that inform sexual behaviour and understand sexual relationships and gender inequalities between men and women (Walker et al, 2004).

Foreman (1999) argues that the global AIDS epidemic is driven by men. Men have more opportunity to contract and transmit HIV, men usually determine the circumstances of intercourse and men often refuse to protect themselves and their partners. If this be the case, why is it that women are the most infected? What makes women more susceptible to HIV/AIDS? Walker et al (2004) postulate that there is no single explanation for the HIV/AIDS epidemic in South Africa.



A unique combination of factors influence the pattern and profile of the epidemic. The mix of poverty, violence, cultural practices, migrancy and gender inequalities have created an environment in which the disease is thriving.

The scope and scale of the HIV/AIDS epidemic in South Africa is almost beyond belief. The statistics appear to be simply unable to capture the human tragedy and the hugeness of the challenge facing South Africa and Africa as a whole.

1.2 MOTIVATION

In South Africa the diagnosis of HIV/AIDS appears to have become more equivalent to a death sentence. The emerging literature on HIV/AIDS suggests that the psychological sequelae of HIV/AIDS may differ for men and women, for instance; women report more psychological distress than men (Kennedy, 1995). Furthermore, Van Servellen, Sarna, & Jablonski (1998a) studied 150 HIV-positive women attending the antenatal and outpatient clinics in Atlanta Georgia and observed major levels of distress, limits on normal functioning and disturbances to physical well being together with both anxiety and depression. Many studies have also reported greater incidence of psychopathology or psychiatric morbidity in women than in men (Meller, 1994; Freeman, 2003).



In spite of this the mental health sector seems to have lagged behind in engaging with HIV/AIDS.

According to South African Institute for Traumatic Stress (2003) there has been very little dialogue in the country about the mental health and psychological impact of HIV/AIDS. Moreover within the recent fanfare and focus on mental health promotion, the disease which has the potential to most seriously damage global mental health status, HIV/AIDS has received relatively little mental health attention (Freeman, 2003). For example, during 2002 when the real crisis of this epidemic began to be felt in communities, in the popular media, amongst NGOs and government, this very journal carried not a single article on psychological aspects of HIV/AIDS.

The previous year, there was only one related article (Van Dyk, 2001). The only psychological focus that there is on HIV/AIDS is on pre and post-test counselling which is also within a prevention framework. One possible reason why psychological issues regarding HIV/AIDS have not received enough attention could be attributed to the belief that mental health problems are not “real” and cannot be treated effectively and this result in an increasing burden with a disproportionate public health response (Cohen, Kleinman & Saraceno, 2002).

Questions that arise are; what is the psychological impact of the disease on one who is infected, who are most likely to be affected by HIV/AIDS? What is the impact of living with the disease and the stigma associated with it on those affected by it? Are women more likely to be infected than men? And if so why? Does HIV/AIDS disease follow a different course in women compared to men? What are social factors that impinge on women infected or affected by HIV/AIDS? Do women with HIV infection have different emotional needs from men? What particular issues arise for men and women in counselling? All these questions point to the importance of mental health engaging with HIV/AIDS issues. This is particularly so in the area of traumatic stress. Very little conversation has taken place about the link between HIV/AIDS and trauma. Most trauma specialists in South Africa are still focusing on victim empowerment and violence (SAITS, 2003).

All the above questions begged for a need to find answers since those questions seem to be significant to the issue of HIV/AIDS in every way imaginable, therefore the current study was birthed. There is a multiplicity of reasons as to why this research needs to be undertaken. Firstly, a diagnosis of an illness such as HIV infection

presents a threat to life after an interval of uncertain duration. Such threat of impending death may present for years before the development of overt signs of illness and may become a form of chronic adversity compounding both the physical and psychological well being of an infected person (Kelly & Raphael, 1992).

A perusal of the literature indicates that posttraumatic stress symptoms that occur in response to the personal trauma of a diagnosis of a life threatening illness is an area of limited exploration, therefore this study seeks to make such information available for clinicians working with such patients. Studies to date suggest high levels of distress and disorder among those patients diagnosed with life threatening illness such as cancer making it difficult for the infected persons to cope (Dilley, Ochitill, Perls, Volberding, Perry & Tross, 1985, Leuken & Compass, 2002).

Secondly, the diagnosis of HIV infection may place an individual at the focus of harsh social stigma and discrimination. All affected groups may be stigmatized by the community stereotypes of HIV/AIDS (Bishop, 1994, Cassens, 1995). As a result an infected person may be unable to share the news of the diagnosis with others because of the fear, guilt, and shame of being ostracized. Multiple deaths and death of a partner(s) are also prevalent among those infected with HIV/AIDS. All these psychosocial issues are likely to alter the disease progression. Those at earlier stages though unimpaired physically by the infection, may nevertheless experience considerable psychological disability (Kelly & Raphael, 1992).

Therefore the interrelation between stages of disease severity is important to consider using the models of posttraumatic phenomena to define clearly the changing cognitive

and emotional processes that occur. Understanding of such aspects of adaptation is important in providing a more empirically based approach to the psychological care of affected persons.

Thirdly, UNAIDS (2002) estimates that over 13 million women in Africa are living with HIV, compared to 11 million men. AIDS seems to be the leading cause of death for women aged 19 to 40 and infant mortality rates have increased as a result of prenatal HIV transmission. Women are more likely than men to be infected with HIV through heterosexual sex for biological, epidemiological and social reasons (WHO, 1998). For women and men, the basic biological processes that accompany HIV are likely to operate in the same way; however sex differences in the clinical manifestations of HIV are prevalent (Massad, Riester, Anatos, Fruichter, Palesky, Burk, Burns, & Motti 1999).



Most sex differences in disease manifestation have been documented in areas in which women and men differ fundamentally (i.e. gynaecological complications), however, these manifestations were not fully realized as symptomatic of progression to AIDS for women until years into the AIDS epidemic. In areas where there has been no clear documentation of differences between men and women (e.g. neurological complications) it is unknown whether this is a result of null finding or due to the lack of information on women and HIV available in research (Ickovics, Beren, Grigorenko, Duley, Morrill & Rodin, 2000). Evidence regarding sex differences in the clinical course of HIV disease and survival rates has been inconsistent.

Many recent studies do not report sex- differences in the rate of clinical progression (Smith & Moore, 1995, Cu- Uvin, Rich, Mileno, Meyer, & Carpenter, 1996). Furthermore Farzadegan, Hoover, Astemborki, Lyles, Markhams, Quinn and Vlahov (1998) found that women with the same viral load as men had a 1.6 times greater risk of AIDS indicating perhaps that disease progression for women is more rapid than for men. It is in the light of the above considerations that this research seeks to provide a gender based approach to the analysis of the posttraumatic stress reactions and impact of HIV infection, to help explain why a virus that affects both men and women appear to affect women somewhat differently both psychologically and biologically. Such information will be useful to inform and drive policy, so that there should be forums for interaction of programs. The value of policy orientated research and evidence-based practice of HIV/AIDS cannot be over emphasized.



Lastly, the knowledge about HIV/AIDS, traumatic stress and gender is mainly found in literature from developed countries. This raises concerns as to how research from developed countries can be extrapolated to South Africa and other developing countries. Freeman (2003) attributes huge differences that exist between developed and developing countries both in research and intervention perspective to the following:

- Differences in prevalence and incidence rates
- Availability of skilled resources
- The Cultural milieu
- HIV/AIDS Treatment

It is without debate that research relevant to the South African context is invaluable and vital.

1.3 DEFINITION OF TERMS

The definition of AIDS has changed over time as researchers have learned more about the disease. The Centres for Disease Control and Prevention (CDC) (1981, P.97) initially described AIDS as “the presence of a disease moderately predictive of a defect in cell mediated immunity, occurring in a person with no known cause for diminished resistance to that disease”. By 1982 and 1983, the disease (AIDS) was reported in adult heterosexuals and children because a cellular deficiency of the human immune system was found in every AIDS patient, along with an assortment of other signs and symptoms of disease.

Since it was discovered that the infection was acquired from action of some environmental agents, it was then named AIDS for acquired immune deficiency syndrome (Stine, 2004). Urquhart (1995) further argues that in order to “fight AIDS” it is necessary for the medical profession to present the conditions that are symptomatic of the different disease that comprise AIDS as one disease. For that reason there has been a clinical construction of AIDS as developing through time, in defined stages from; seropositivity to development of “signs” of AIDS related complex (ARC) to AIDS as something identifiable and whole in itself. Skhosana (2001) argues that the unfortunate side-effect of this conceptualisation of AIDS is that among a large percentage of the population in South Africa, the diagnosis of HIV

continues to mean death. The significance lies not in the medical condition but in the social construction of death that people perceive or even experience.

Urquhart (1995) concludes that medicine in its clinical conception of AIDS reproduces a specific social construction of AIDS as inevitable and fatal which uses itself, for the medical profession is increasingly concerning itself with future predictions about the disease based on these conceptions. However, in using these conceptions, medicine is “creating a class of lifetime pariahs, the future ill... (and in that process) bringing a societal death before a physical one. The result is that medicine, in developing a construction it can understand, abandons the patient as doomed” (Uquhart, 1995, p.34). The above assertion is clearly illustrates how important socio-cultural factors are when dealing with people who are diagnosed with HIV/AIDS.



As alluded to in the above sections, HIV/AIDS presents a serious challenge to the world moreover to Africa and South Africa because of the devastating impact that it has on communities. Psychoneuroimmunology, which examines the interrelationships between psychosocial factors and the immune, nervous and endocrine systems have contributed much to the understanding of the clinical progression of HIV/AIDS (Bishop, 1994). Researchers in this area have found increasing evidence that the immune system’s functioning is influenced by a person’s emotional state, stress, life satisfaction and social relationships (Bishop, 1994; Coates, Mandel & Temoshok, 1984; Cohen, 1988; Cohen & Willis, 1985; O’Leary, 1990). Specifically, evidence seems to indicate that the stress a person is experiencing can suppress the immune system (Bishop, 1994; Coates et al, 1984; Essex, Mboup, Marlink, Kanki & Tlou,

2002, Zijenah & Katzenstein, 2001).

Since there is no known cure for HIV/AIDS it is vital that the mental health sector to engage with the issue to assist in managing the effects thereof on both the infected and affected.

An HIV-positive notification may evoke a myriad of emotions that may become a major source of stress and anxiety exacerbated by a threat of one's impending death. A study by Steven & Doerr (1997) revealed that the discovery of being HIV-positive is a traumatic event carrying with it elements that are common to other types of trauma such as fear, helplessness and perceived threat to one's life. There has been a consistent recognition that traumatic incidents can induce profound emotional and physical symptoms in previously healthy individuals (Schnurr & Green, 2004).

According to SAITS (2003) there seem to be a major split between those who work with HIV/AIDS and those working with trauma. Trauma specialists possess much expertise on trauma and its impact on human functioning and well being. On the other hand those working with HIV/AIDS also possess knowledge about their field but with little understanding of the traumatic nature of the disease. In order to understand how the two fields could work together there must be an understanding of the link between them.

The current study concerns itself with the recent American Psychological Association (APA) definition of trauma as indicated in the DSM-IV-TR. APA (2000) assert that although exposure to catastrophic stress is a necessary condition, it is insufficient by

itself to traumatise an individual. The critical discriminator is the person's emotional response to such an event. If the rape or incident produces an intense emotional response characterized in the DSM-IV-TR as fear, helplessness, or horror the event is traumatic. If an event does not produce an intense emotional response, then the event is not considered a traumatic event and, according to the DSM-definition, cannot cause PTSD.

Freeman (2003) maintains that there is a causal relationship that exists between trauma and HIV/AIDS and this relationship goes both ways. Therefore the existing conceptualisation in the trauma field is likely to assist in the understanding and dealing with HIV/AIDS, on the other hand the HIV/AIDS epidemic is also likely to force the trauma field to re-conceptualise some of its concepts in order to provide a more empirically based approach to the psychological care of persons who are affected by chronic and life threatening illness and to provide a more substantial systematic basis for counselling and other therapeutic techniques (Kelly & Raphael, 1992).

This study also concerns itself with an interactional model of traumatic stress reactions which is systemic in nature. It attempts to specify how excessive stress is likely to alter personality functioning in pathological or non pathological ways (Wilson, 1989). Theoretical approaches to the study of human behaviour have recognised the need for interactional models that specify how many variables work together to create socio psychological and psychobiological processes. Interactional models of behaviour attempt to identify the central elements for theoretical hypotheses that specify patterns of interactions that codetermine different forms of

adaptive behaviour (Wilson, 1989). This approach asserts that posttraumatic adaptation is determined by the classes of variables and include; (1) the nature and dimensions of the trauma; (2) personality attributes; (3) the nature of the recovery environment and (4) the coping resources of a person. It is believed that these variables interact in influencing both pathological and non pathological forms of stressful life events.

In order to assess the phenomenon of trauma the Impact of Event Scale-Revised (Weisman & Marmar, 1997) will be utilised. The IES-Revised is similar to IES in that it is a self-report measure designed to assess current subjective distress for any specific life event. The IES-R has 22 items, seven items having being added to the original 15-item IES (Weiss & Marmar, 1997). The seven items comprise six that measures hyperarousal symptoms such as: anger and irritability, heightened startle response, difficulty concentrating, hypervigilance; and one new intrusion item that measure the dissociative-like re-experiencing when experiencing true flash-back.

In their study of four different population samples, Weiss & Marmar (1997) reported that the internal consistency of the three subscales was found to be very high. In terms of validity Weiss & Marmar (1997) noted that the hyperarousal subscale has good predictive validity with regard to trauma (Briere, 1997).

The second scale to be used is called Mental Adjustment to HIV (Kelly, Raphael, Burrows, Kernutt, Burnett, Perdices & Watson, 2000). The original scale that was forty-item Mental Adjustment to Cancer Scale (Greer, Young & Watson, 1998) was modified by Kelly et al (2000) for use in HIV infection (Mental Adjustment to HIV

Scale). Instructions for the original instrument were modified to address “reactions to having HIV infection or AIDS” (rather than cancer) and individual items modified for HIV infection by replacing “cancer” with HIV infection or AIDS, similar to the modifications reported by Ross, Hunter & Condon (1994). The scale was modified in order to be applicable to those who are diagnosed with HIV/AIDS and to further identify items that are unique to HIV/AIDS.

In the Study by Ross et al (1994) five factors were detected on the MAHIVS of which only two had high internal consistency scores. Moreover the pattern observed with the group of 167 HIV-positive men in a study by Kelly et al (2000) is similar to that found by Schwartz, Daltroy, Brandt, Friedman & Stolbach (1992) in a study of 239 cancer patients as both studies detect a factor of hopelessness and varying forms of positive attitudinal reactions. The validity of the MAHIVS was found to be high and supported by the significant correlation between factors (Hopelessness and Fighting Spirit) with significant correlations detected between psychological symptoms and other measures of psychological adjustment and personality.

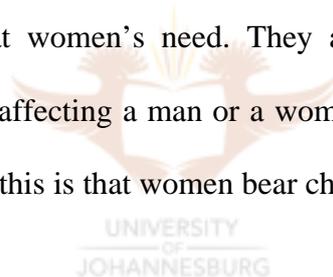
Therefore the two scales to be used appear to be of significance to the current study focus. The following section focuses on the general problem statement for the current study.

1.4 GENERAL PROBLEM STATEMENT

When AIDS was first described in the early 1980's it was thought to be a disease that affected only gay men. It was not long before AIDS was recognized to be the same

disease that was killing many people in Africa, both male and female. By 1982 it was accepted that AIDS had an infective cause and in 1984 the virus that was subsequently named HIV was isolated (Bury, Morrison & McLachlan, 1992). And yet many people in the West continued to see AIDS as a disease of gay men and assumed that other people including women would not be at risk and that somehow inexplicably Africa was different.

According to Bury et al (1992) the first AIDS conference was held in May 1988 entitled “Women and AIDS issues, needs, and awareness”. It addressed the implications of AIDS for women by presenting an overview of medical, social and counselling issues. In the early days of the network, there were those who asked why there was a need to look at women’s need. They argued that “AIDS is AIDS” regardless of whether it was affecting a man or a woman. Bury et al (1992) add that the most obvious response to this is that women bear children and men do not.



However the ability to bear children is not the only factor that distinguishes women from men, and as the epidemic has progressed, it has become clear that there are many other questions to which researchers have wanted answers such as; Does HIV/AIDS affect men and women the same way? If yes, does it follow a different or similar course in women compared to men?

Therefore the aim of this study is to attempt to find answers to the above questions by comparing the posttraumatic symptoms in men and women who are diagnosed with HIV-infection and to further investigate how their reactions are likely to impact on their disease progression and adjustment.

1.5 SPECIFIC PROBLEM STATEMENT

The hypotheses to be examined in this study are that in those individuals diagnosed with HIV infection patterns of posttraumatic symptoms in response to the diagnosis of HIV infection would be present and would form a crucial component of the distress that is experienced and are likely to affect adjustment to illness. Therefore the main hypotheses to be examined in this study are as follows:

- Null hypothesis 1: There will be no significant differences between men and women diagnosed with HIV/AIDS in terms of their overall post traumatic symptoms in reaction to news about their HIV-positive status.
- Null hypothesis 2: There will be no significant differences between men and women diagnosed with HIV/AIDS in terms of Fighting Spirit.
- Null hypothesis 3: There will be no significant differences between men and women diagnosed with HIV/AIDS in terms of Hopelessness.
- Null hypothesis 4: There will be no significant correlations between Impact of Event and Fighting Spirit.
- Null hypothesis 5: There will be no significant correlation between Impact of Event and Hopelessness.

1.6 APPLICABILITY OF THE STUDY

The knowledge about HIV/AIDS, traumatic stress and gender is mainly found in literature from developed countries. This raises concerns as to how research from developed countries can be extrapolated to South Africa and other developing

countries. Freeman (2003) attributes huge differences that exist between developed and developing countries both in research and intervention perspective to the following:

- Differences in prevalence and incidence rates
- Availability of skilled resources
- The Cultural milieu

Therefore the current study will attempt to contribute to the latter, knowledge that could assist those working in the area of HIV/AIDS and making policies to better understand the complexities that exists between men and women diagnosed with HIV/AIDS. Moreover, to also assist in providing baseline information for more research in this area, since there appears to be very little information from studies in South Africa on the matter.



1.7 CHAPTER SUMMARY

This chapter presented an overview of the current study which concerns itself with the issue of HIV/AIDS and posttraumatic reactions of men and women living with HIV/AIDS. The motivation for the current study and the significance thereof were also addressed. Lastly, a discussion on the type of instruments to be utilised in the current study and problem statements were discussed. The following chapter will explore literatures in an attempt to provide a theoretical background on issues that the current study seeks to interrogate.

CHAPTER TWO



AN OVERVIEW OF HIV/AIDS

“The unfolding epidemic a tale of courage as well as cowardice of compassion and bigotry of inspiration and redemption and despair” (Shilt, 1987).

2.1 INTRODUCTION

HIV/AIDS seems to pose an enormous challenge to human life and development. The repercussions of the epidemic are extreme, affecting all aspects of human society and organisation. Over two-thirds of the world’s people living with HIV/AIDS are in sub-Saharan Africa. Today, it is estimated that six out of every ten men, eight out of every ten women and nine out of ten children living with HIV/AIDS are in Africa (UNAIDS, 1998). In some communities a vicious cycle of deepening poverty and rising rates of infection is undermining past progress, in many regions of Southern Africa more than a quarter of adults are living with HIV/AIDS.

Unlike most diseases, HIV/AIDS also seems to affect the most economically productive sector of the population as well, healthy sexually active men and women of the world. The whole population of the world indeed because the epidemic is by no means confined to Africa. In particular it is spreading quickly across parts of South and East Asia and countries with large populations such as India and China. Globally,

the epidemic is increasingly affecting younger people. Roughly, half of all people living with HIV are aged ten and 24 years (Webb, 2000). A question may arise as to what the meaning of HIV/AIDS is and its defining features?

2.1.1 Definition of HIV/AIDS

In 1981, the acquired immunodeficiency syndrome (AIDS) was identified as a new disease, initially in homosexual men in the United States of America. However, the analysis of specimens retained from people who had died previously has shown that cases of HIV infection were present as early as 1959, suggesting that, in the 1960s and the 1970s, HIV-related disorders and AIDS were increasingly common but unrecognised, particularly in Africa and North America (Kaplan & Sadock, 1994).

The definition of AIDS has changed over time as researchers have learned more about the disease. The Centres for Disease Control and Prevention (CDC) (1981, P.97) initially described AIDS as “the presence of a disease moderately predictive of a defect in cell mediated immunity, occurring in a person with no known cause for diminished resistance to that disease”. By 1982 and 1983, the disease (AIDS) was reported in adult heterosexuals and children because a cellular deficiency of the human immune system was found in every AIDS patient, along with an assortment of other signs and symptoms of disease.

Since it was discovered that the infection was acquired from action of some environmental agents, it was then named AIDS for acquired immune deficiency syndrome (Stine, 2004).

Guidelines for a classification system for clinical symptoms associated with the disease were issued by the Centers of Disease Control in 1986 (Ragsdale & Morrow, 1990). There has been a steady progression in scientific and medical knowledge about HIV/AIDS progression toward more effective treatment for the disease. Two of the early benchmarks in this progression were the identification of human immunodeficiency virus (HIV) infection as the agent responsible for AIDS and a re-conceptualisation of the disease progress away from its focus on AIDS alone toward a larger spectrum of HIV- related conditions.

Since the discovery of human immunodeficiency virus (HIV) there is consensus among researchers that acquired immunodeficiency syndrome (AIDS) result from infection by the immunodeficiency virus (HIV), which is causally related to a broad array of other medical conditions and neuropsychiatric syndromes (CDC, 1983; Kaplan & Sadock, 1994; Ragsdale & Morrow, 1990).



Recent literature on HIV/AIDS assert that HIV is a ribonucleic acid (RNA)-containing retrovirus that was isolated and identified in 1983. HIV infects cells of the immune system and nervous system. Infection of mononuclear cells otherwise known as T4 helper lymphocytes that are critical in immune defence because they provide the specificity and memory needed for immune function and long-term immunity eventually results in impaired cell mediated immunity, dramatically limiting the ability of the body to protect itself from other infectious agents. Infection of cells known as primary astrocytes within the central nervous system (CNS) results directly in the development of neuropsychiatric syndromes, which are commonly further complicated in patients with AIDS by the neuropsychiatric effects of opportunistic

CNS infections, CNS neoplasms, independent psychiatric syndromes and myriad psychological stresses related to having an HIV-related disorder (Kaplan & Sadock, 1999).

Other conditions considered indicative of AIDS are HIV encephalopathy, HIV wasting syndrome, recurrent salmonella septicaemia, lymphoid interstitial pneumonia, extra-pulmonary tuberculosis and multiple recurrent pyogenic infections in children (CDC, 1983; Kaplan & Sadock, 1994; Ragsdale & Morrow, 1990).

2.1.2 Stages of HIV infection

The Centers for Disease Control and Prevention (1987) published AIDS criteria which are still commonly used in which AIDS is classified into four groups namely;

- Group I known as seroconversion of illness stage,
- Group II known as asymptomatic infection stage,
- Group III known as symptomatic infection stage and
- Group IV known as full blown AIDS stage.

Each of the above stages will be briefly explored in a discussion to follow wherein the various factors that characterises each stage will be described.

The majority of people in *Group I* remain asymptomatic. Some may experience flu or mononucleosis-like symptoms that generally appear in a few weeks, In relatively few cases the patient moves rapidly from mild symptoms into sever infections and is diagnosed with AIDS. In *Group II*, antibodies are present but most people remain free of symptoms of HIV infection. Regardless of the lack of outward clinical symptoms,

90% of those who are asymptomatic experience some form of immunological deterioration within five years (Fauci, 1988).

In Group III, asymptomatic people from Group I and II become symptomatic and demonstrate lymphadenopathy in the neck, armpit and groin areas. Although a number of other diseases may cause the lymph nodes to swell, most swelling declines as the other symptoms of illness fade. However with HIV infection, the lymph nodes remain swollen for months, with no other signs of a related disease. Consequently, lymphadenopathy is sometimes called persistent generalised lymphadenopathy (PGL). People with PGL may also experience night sweats, weight loss, fever, frequent diarrhoea, fatigue and the onset of oral thrush. Such signs and symptoms are symptoms leading for AIDS. Studies have shown that people in Group III appear to become more infectious as the disease progresses.

People in Group IV qualify to be diagnosed with AIDS according to the CDC classification (CDC, 1987). Hairy leukoplakia is virtually diagnostic of AIDS. Statistics show that about 30% of all the newly HIV-infected will progress to Group IV (full blown AIDS) every five years. Recent literatures on HIV/AIDS state that in 1993, the newest definition of AIDS was put into surveillance network. The reason for the new CDC definition was that epidemiologists felt that the 1987 definition failed to reflect the true magnitude of the pandemic (Stine, 2004). In particular, it failed to address AIDS in women. In addition, those with T4 counts under 200 of blood are most likely to be severely ill or disabled and in greatest need of medical and psychological services.

CDC (1993) revised the classification system for HIV infection to emphasise the clinical importance of the T4 lymphocyte count in the categorisation of HIV-related clinical conditions. The expanded classification included pulmonary tuberculosis, invasive cervical cancer and the recurrent pneumonia (CDC, 1993). The objective of these changes are to simplify the classification of HIV infection and the AIDS case reporting process to be consistent with standards of medical care for HIV-infected persons in those countries where medical treatment is available.

It is evident from the above discussion that HIV/AIDS is devastating for the individual who may be infected and its impact on communities and societies is likely to be enormous. Since HIV/AIDS is a disease with broad manifestations, the goal of this chapter is to provide an overview of HIV/AIDS by specifically focusing on the progression of the disease and issues of HIV/AIDS transmission.

2.2 DISEASE PROGRESSION



There are several classifications that spell out the progression of signs and symptoms from HIV infection to the diagnosis of AIDS. The classifications were developed to provide a framework for the medical management of patients from the time of infection through the expression of AIDS (Royce, 1991). All classification systems are fundamentally the same in that they group patients according to their stage of infection, based on signs that indicate a failing immune system which is an incredibly complex network of organs containing cells that recognise foreign substances in the body and destroy them (Stine, 2004). The most widely accepted classification because of its greater clinical applicability comes from CDC (1987)'s latest classification

system as alluded to in the above discussion.

However, the period for progression from primary HIV infection to terminal stage AIDS varies from person to person. It ranges from one year to more than 20 years, with a median time to onset of AIDS nearly 10 years after infection. This variable time to onset may depend upon host susceptibility, viral virulence, immune responses against the virus and endogenous and exogenous co-pathogens (Zijenah & Katzenstein, 2001).

Psychoneuroimmunology, which examines the interrelationships between psychosocial factors and the immune, nervous and endocrine systems have contributed much to the understanding of the clinical progression of HIV/AIDS (Bishop, 1994). Researchers in this area have found increasing evidence that the immune system's functioning is influenced by a person's emotional state, stress, life satisfaction and social relationships (Bishop, 1994; Coates, Mandel & Temoshok, 1984; Cohen, 1988; Cohen & Willis, 1985; O'Leary, 1990). Specifically, evidence seems to indicate that the stress a person is experiencing can suppress the immune system (Bishop, 1994; Coates et al, 1984; Essex, Mboup, Marlink, Kanki & Tlou, 2002, Zijenah & Katzenstein, 2001).

Research findings also indicate that the effects of stress on the immune functioning are influenced by variables such as the person's coping style and the duration of the stressful events. For example, transient stress is of less concern than prolonged stress, as it is the enduring stresses that produce measurable changes in the immune system (Kelly & St Lawrence, 1988; Compass & Compass, 2002). This finding correspond

with that of O'Leary (1990) who found that chronic stress has been associated with suppression of the immune system, and that the immune system may not adapt over time. Moreover, a passive coping style of dealing with stress is of particular concern since it is associated with suppression of the immune system (Bishop, 1994).

Coates et al (1984) suggest that immuno-suppression which refers to the suppression of the immune system observed in AIDS is linked to the interaction of genetic, environmental and psychosocial factors that may either protect the person, or influence the course or progression of the disease. The findings of this study seem to be consistent with that of Kelly & Lawrence (1988) who state that the role of genetic characteristics of the host may influence whether an infected person stays healthy, develops mild symptoms of immuno-compromise or develops AIDS.

Coates et al (1984) propose an alternative theory to explain why only certain individuals develop AIDS while others, who could have been exposed to the virus, were able to resist it. They suggest that AIDS is an opportunistic infection causing disease only in those who are already infected. Factors implicated in immuno-suppression include multiple infections, drug use, repeated exposure to the virus and antibiotics. Later research in the field of psycho-immunology seems to suggest that a complex interrelationship of several independent factors such as viral strain, genetic susceptibility, nutritional status, lifestyle practices and antiretroviral therapy may modulate the rate of HIV /AIDS disease progression (Easterbrook, 1994; Mulder & Antoni, 1992).

HIV-infected people who are asymptomatic show wide variation in how they respond

to HIV-infection and progression to AIDS. It is believed that cofactors may be responsible for time variation with regard to disease progression (Stine, 2004). Many agents may act as cofactors to activate or increase HIV production. Although, in general, researchers believed that any cofactor is necessary for HIV infection, cofactors such as nutrition, stress and infectious organisms have been considered as important agents that accelerate HIV expression after infection.

Three new human herpes viruses namely; cytomegalovirus (CMV) which is a parasite and infects most people asymptotically, herpes virus type one & two which affect the membrane of nose and mouth have been found to be possible cofactors and may play a role in causing immune deficiency (Stine, 2004).

According to investigators, other sexual disease that behaves as cofactors associated with HIV infection and expression are expected to be found over time. Drugs may also be cofactors in infection. Used by injection drug users, heroin and other morphine based derivatives are known to reduce human resistance to infection and produce immunological suppression. Recent findings indicate that pneumocystis carinii pneumonia is about twice as frequent in heroin users as in homosexuals. It is believed that heroin has an immuno-suppressive effect within the lungs (Brown, 1987; Stine, 2004). Seminal fluid which is the fluid bathing the sperm may also act a cofactor in infection because it also causes immuno-suppression. One of its physiological functions is to immuno-suppress the female genital tract so that the sperm is not immunologically rejected (Baxena, 1985; Stine, 2004; Witkins & Sonnabend, 1983).

Last but not least of the agents that can suppress the immune system and thereby act as a cofactor in HIV infection is stress. Stress can be psychological or physical. Chuang, Devins, Hunsley & Gill (1989) assert that psychosocial issues and adaptive demands are likely to alter the disease progression. Those at earlier stages, although unimpaired physically by the infection may nevertheless experience considerable psychosocial disability and distress thus compromising their immune system even further.

The following section will focus on issues of transmission which are of significance considering the fact that HIV/AIDS is a fatal disease with no cure, and in most countries of the world, HIV/AIDS has continued to reach the epidemic stage. Researchers are currently conducting a number of studies to investigate factors responsible for the wide spread of HIV/AIDS.

2.3 HIV/AIDS TRANSMISSION

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Transmission of HIV most often occurs through sexual intercourse or through transfer of contaminated blood from one person to another. Unprotected anal or vaginal sex are the sexual activities most likely to transmit the virus. Oral sex has been implicated, but rarely. After transmission the virus replicates in one or more types of susceptible cells (Kaplan & Sadock, 1998). The discussion to follow explores the above methods of HIV transmission and their implications in detail.

2.3.1 Global modes of HIV transmission

Once the HIV enters the body it is then present in the blood, the semen, cervical and vaginal secretions and to a smaller extent the saliva, tears, breast milk and cerebrospinal fluid of infected persons. Transmission of HIV most often occurs through sexual intercourse or the transfer of contaminated blood between persons (Kaplan & Sadock, 1994). Unprotected anal, vaginal and oral sexes are sexual activities most likely to transmit the virus. Although male-to-male transmission has been the first to be discovered most, common route of sexual transmission, male-to-female transmission and female-to-male transmission have also been documented and represent an increasing large percentage of transmission routes.

Some studies have found that about 50 percent of the regular sex partners of HIV-infected persons have become infected themselves, suggesting that some persons have as yet not understood resistance to HIV infection (Graham, Zeger, Park, Vermund, Detels, Rinaldo & Phair, 1992; Goldfinger & Robinowitz, 1990). Transmission by contaminated blood most often occurs when intravenous (IV) substance-dependent persons share hypodermic needles without sterilisation technique. Children can also be infected through breast feeding when their mothers are infected with HIV. No evidence has been found that HIV can be contracted through casual contact, such as sharing a living space, a toilet seat or a classroom with an HIV-infected person (Kaplan & Sadock, 1994).

Worldwide there are now three major types or patterns of the HIV epidemic unfolding. The first pattern is occurring in wealthy countries, such as the United States of America, where the epidemics are heterogeneous but dominantly involve male to male sexual transmission. After a long period of decline, those epidemics are

now showing troubling signs of resurgence, largely due to unsafe sexual practices among gay men (Stine, 2004).

The second pattern is seen in Sub Saharan Africa and Latin America, driven by heterosexual transmission. According to Stine (2004) Africa continues to have the largest number of people living and dying of AIDS. Kristensen, Sinkala & Vermind (2001) assert that Sub Saharan Africa alone bears an estimated 70% of the current burden of HIV/AIDS. It is estimated that 25.3 of the 36.1 million people living with HIV/AIDS live in Sub Saharan Africa. Of all the AIDS related deaths since the start of the epidemic (17.5 million adults and 4.3 million children) over three fourths have occurred in Africa. Sexual transmission of HIV causes 75% to 85% of HIV infections worldwide.

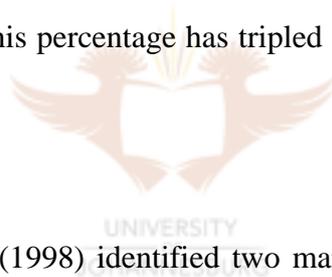


The third pattern which has been labelled as explosive by the UNAIDS has almost nothing to do with sex. It is driven by needles shared among people who inject narcotics. All over the world the narcotics-driven HIV-pandemic seems to begin, unnoticed by government officials, in isolated communities of injection drug users, spreads like wild fire and then suddenly takes on national significance (Stine, 2004).

It is evident from the above discussion that now into the third decade of AIDS, the disease HIV/AIDS remains a great challenge to public health, human rights and human development. Stine (2004) postulates that this is the first plague in the era of globalization. The figures are alarming over the last five years; 1999 through 2004, about 30 million people became infected with HIV, bringing the total number of infections to about 75 million since the outbreak of this pandemic.

2.3.2 Infection rates

According to UNAIDS (1999) there was an estimated 40 million adults infected with HIV at the turn of the century. Women account for 44% of all estimated HIV infections worldwide, and the proportion of women infected is rapidly increasing in every geographic region. Recent literature indicates that in Sub Saharan Africa, women are more infected than men with HIV/AIDS. Not only are women in Africa disproportionately infected but HIV infection also places women at particularly increased risk of rejection, loss of security, stigma and violence (Tlou, 2001). A similar trend has been observed in the United States. In 1985, only 6.5% of newly diagnosed cases of HIV/AIDS were among women (Centers for Disease Control, 1986). Thirteen years later, this percentage has tripled to 23% in the United States of America (CDC, 1998).



Centers for Disease Control (1998) identified two main routes of HIV transmission among women. These include sharing of needles by injection drug users and heterosexual sex. Heterosexual intercourse has been identified as the main route of HIV infection among women globally. According to the World Health Organization (1998) women are more likely to be infected with HIV through heterosexual sex for biological, epidemiological and social reasons. Male to female transmission of HIV is estimated to be eight times more likely than female to male transmission (Padian, Shiboski, Glass & Vittinghoff, 1997).

As the receptive sexual partner in heterosexual activity, women are more at risk for HIV and other sexually transmitted diseases for anatomical reasons; the mucosal

tissue lining the walls of the vagina is fragile and prone to injury (Coates & Cohen, 1997). UNAIDS (1998) estimates that over 13 million women in Africa are living with HIV, compared to 10 million men.

AIDS is also said to be a leading cause of death for women aged 19 to 40 in Africa. Currently, about one in four women attending antenatal clinics in South Africa are infected with HIV, which translates into 10% of the entire population (Harrison, Smit & Myer, 2000).

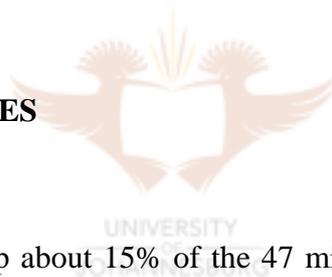
Recent studies indicate that women are becoming more infected, but despite the increasing infection rate in women, few published studies specifically address their psychological sequelae and adaptation issues. Much of what we know about HIV/AIDS comes from studies of gay and bisexual men (Smith & Moore, 1996). However, these findings may not be fully generalised to heterosexual men and women.

The emerging literature on HIV/AIDS further suggests that the psychological sequelae of HIV/AIDS may differ for men and women, for instance; women report more psychological distress than men (Kennedy, 1995). Furthermore, Van Servelleni, Sarna & Jablonski (1998) studied 150 HIV positive women attending the antenatal and outpatient clinics in Atlanta Georgia and observed major levels of distress, limits on normal functioning and disturbances to physical well being together with both anxiety and depression. Many studies have also reported greater incidence of psychopathology or psychiatric morbidity in women than in men (Meller, 1994; Freeman, 2003).

Farzaden, Hoover, Astemborki, Lyles, Markhams, Quinn & Vlahov (1998) discovered that women with the same viral load as men had 1.6 times greater risk of AIDS, indicating perhaps that disease progression for women is more rapid than men. These findings raise questions regarding differences between men and women in relation to HIV/AIDS.

Is it possible for a disease that affects both men and women to affect them differently? Apart from obvious physiological differences between men and women, could there be other differences in terms psychological sequelae, adaptation to a chronic illness, survival, socio culturally and politically? All these questions and many others are to be addressed in the next section.

2.4 GENDER DIFFERENCES



Women over age 15 make up about 15% of the 47 million people worldwide living with HIV/AIDS. The heightened vulnerability that gender inequality has created is now evident across the world, with approximately 50% of all new adult infections occurring in women (Kwakwa, 2000). In sub Saharan Africa, 58% of HIV-positive adults are women. In parts of Latin America and the Caribbean the proportion has reached as high as 45% and this figure is on the rise.

Figures published by UNAIDS (2001) show that the risk of infection is increasing for women everywhere in both developed and developing countries. For example, in France, women's share of reported AIDS cases increased from 12% in 1985 to 20% in 1995. In Brazil the proportion of AIDS cases in women rose from 1% in 1984 to 25%

in 1995 (UNAIDS, 1999).

Literature on women and HIV/AIDS reveals many variations in handling, caring and life roles, specifically in terms of pregnancy and childbearing. There is also some evidence on different approaches to safe sex and benefits in HIV related decisions (Sherr, Hankins & Bennett, 1996). The systematic effects of gender must raise a number of questions, the first of which is whether or not women are discriminated against. This issue is further compounded by the infrequent use of counselling, the use of non-specialized or not properly trained counsellors and a bias in outcome measures towards termination of the pregnancy.

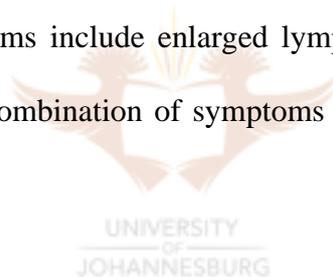
Despite the fact that women have been infected from the start of the epidemic, the move to focus on women, include them in studies, consider treatment trials and even to track the natural history of HIV/AIDS in women occurred late in the day. The inclusion of female specific manifestations of HIV disease has also only recently been considered in the arena of AIDS defining illnesses (Sherr et al, 1996). This may have led to the devastating effects on rights and financial support entitlement of women compared with men.

Nakajima & Rubin (1991) carried out a quantitative study to review HIV related studies in three leading journals over a time period of six years. They identified studies exploring psychosocial ramifications of HIV on a total sample of just under 2500 individuals, yet only 13 of the people (0.5 %) mentioned in all these studies were women.

Gender issues around reproductive rights and exposure to interventions are fascinating areas in the general literature and create the backdrop against which HIV should be viewed. In this section a number of gender differences that exists between men and women in relation to HIV/AIDS will be explored and the implications of those differences in the HIV/AIDS arena.

2.4.1 Biological/ physical differences

HIV/AIDS infection mostly follows the same pattern in men and women. Between a few days and a few months after infection, around the time that the HIV antibody test becomes positive, there may be short illness like flu or glandular fever (Leen & Brettle, 1991). Early symptoms include enlarged lymph nodes, weight loss, fevers, sweats and diarrhoea. This combination of symptoms is sometimes known as AIDS related complex (ARC).



According to Van Benthem (2002) sex differences with respect to response to HIV do exist. CD4 cell counts are higher in women than in men throughout infection and viral loads are lower initially in women than in men. Despite these disparities, women have not been found to have a more rapid clinical progression to AIDS than men. This finding seems to be in contrast with that of Farzaden et al (1998) who found that women with same viral load as men were at greater risk of progressing to AIDS. Ikovics, Hamburger & Vlahov (2001) also reported that although viral loads were lower in women than men, the rates of progression to AIDS were similar.

Though some studies alluded to in the above seem to have yielded contrasting result, there are many considerations that need to be taken into account such as unspecified

sample size, type of research conducted, the duration of research and many other important factors which might have influenced the result.

According to Beral, Peterman, Berkelman & Jaffe (1990) women who have acquired HIV infection heterosexually are more likely to have Kaposi's sarcoma if their partners are bisexual men than if they are injecting drug users. Lassoued, Clauvel, Fegueux, Matheron, Gorin & Oksenhendler (1991) found that women may also develop KS if they have been infected by blood transfusion, although uncommon in women, when it does develop it may spread more rapidly than in men and can be fatal for anatomical reasons.

Women with HIV infection are also more likely to develop gynaecological infections. Genital warts, genital herpes and pelvic inflammatory disease are all common in women with HIV/AIDS, and like thrush, they may be recurrent and severe (Leen & Brettle, 1991). Women with HIV/AIDS have been found to be more likely to develop abnormal cervical smears (cervical dysplasia) and possibly cervical cancer, apparently related to the increased incidence of genital herpes infection (CDC, 1990).

Some studies have found that women are more likely than men to experience severe weight loss associated with HIV/AIDS infection. Both men and women may also experience thinning of hair. These problems are believed to be cause of particular emotional distress to women, who tend to be more concerned than men with their appearance (Leen & Brettle, 1991). Furthermore, Fauci, Stanley & Weissman (1996) discovered that for women and men the basic biological processes that accompany HIV are likely to operate in the same way, however, sex differences in the clinical

manifestations of HIV are prevalent.

Anemia, irregular menses, mucocutaneous candidiasis, vaginitis, genital herpes, dysplasia and cervical cancer are usually common among women (Korn & Abercrombie, 1997; Massad, 1999; Sun, 1997).

Most sex differences in disease manifestation have been documented in areas in which women and men differ fundamentally, for instance; gynaecological complications. However, these manifestations were not fully realised as symptomatic of progression to AIDS for women until years into the AIDS epidemic (Baum, Revenson & Singer, 2001).



2.4.2 Gender differences in the survival of men and women with HIV/AIDS

A number of studies of people with HIV/AIDS have found that women survive a significantly shorter time after the diagnosis of AIDS than men (Rothenberg, Woelfel, Stoneburner, Milberg, Parker & Truman, 1987). Over the last few years men and women have been living longer after diagnosis of AIDS but studies in the United Kingdom and the United States of America indicate that women still survive for a shorter time than men (Lemp, Payne, Neal, Temelso & Rutherford, 1990).

Shorter survival in women could be attributed to socio-cultural and economic factors which they are often confront even before they find out about their HIV-positive diagnosis. HIV/AIDS can sometimes take a much slower course in men who present with Kaposi's sarcoma which is a rare presentation in women. Women tend to come

forward later because they are afraid of being stigmatised and discriminated against in the disease than men, particularly in the United States of America where they have poorer access to health care due to poverty (Bury, Morrison & McLachlan, 1992).

Women may also be slow to come forward because they consider their own health needs after the needs of their families. Another possible explanation for shorter survival could be attributed to biological differences that exist between men and women in disease progression (ACT-UP, 1991).

A recent study in Edinburgh compared the progression of HIV infection in male and female drug users of similar background where all had been receiving good medical care. Even here male drug users were found to survive longer than female drug users (Bury, Morrison & McLachlan, 1992). The authors commented that since many women were principle carers for children they may receive less prophylactic and pre AIDS care. There is clearly a need for more research into the natural history of HIV disease in women.

2.4.3 Gender-based power imbalance and differences

“For women, the norms that define acceptable behaviour, economic dependency and violence have been said to make them vulnerable to HIV” (Jewkes, 2001).

Women with HIV infection used to be described as an “unrecognized population” (Smeltzer & Whipple, 1991). Erben (1990) suggests that women may be at special risk of HIV because of cultural, psychosocial and legal barriers towards protection,

economic vulnerability and attitudes regarding sexuality. In order to understand the barriers that women face with regard to safe sex practices, diagnosis, prevention, treatment, support and protection of rights, it is necessary to examine the power relations within society.

In most cultures gender is not a synonym for sex. Instead it refers to widely shared expectations and norms within a society about appropriate male and female behaviour characteristics and roles (Gupta, 2001). It is a social and cultural construct that differentiates women from men and defines the ways in which women and men should interact with one another. According to Gupta (2001) gender is a culture specific construct. Sherr et al (1996) maintain that the patriarchal social structures have historically and systematically excluded women from those aspects of society that are responsible for leadership, policy formation, resource allocation and decision making.



The power inequalities associated with such exclusion are reflected in and maintained by the social conditioning of women and men, where specific roles attributes and behaviours are considered not only gender appropriate, but gender determined (Sherr et al, 1996). The traditional socialisation of women is at variance with the skills and qualities generally associated with the expression of power, traits such as dependence, passivity, nurturance and other centeredness do not generally function to empower women (Sherr et al, 1996).

However expressions of power involves complex interactions between internal and external conditions, and women differ (as do men) in their sense of, desire, for ability

to express power. According to Sherr et al (1996) women either individually or collectively may experience degrees of powerlessness in response to different contexts, so the woman's vulnerability and powerlessness is likely to be increased at different points in her life (Barnett & Whiteside, 2002; Jewkes, 2001).

Women and men in different cultures experience varying degrees of power over their choices and actions (Erben, 1990; Gupta, 2001). The common denominator is the subordinate role, with the degree of power being in part culturally determined. There is evidence to suggest that the culturally prescribed gender roles, with associated traits and behaviours, impact detrimentally on women's health (Verbrugge, 1989). Congruent with their subordinate role, many women affected by HIV/AIDS belong to disadvantaged social groups and experience the societal powerlessness associated with such membership (Campbell, 1990, Nyamathi, et al, 1990; Walker et al, 2004). Typically men are seen as being responsible for providing for activities outside the home, while women are expected to be responsible for reproductive and productive activities inside the home (Gupta, 2001). Sexuality is another distinct concept from gender yet intimately linked to it. Sexuality is the social construction of biological drive. Gupta (2001) asserts that an individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances and with what outcomes.

Research into cultural beliefs and HIV/AIDS showed that both men and women believe that male sexuality is determined by biology and that men have sexual urges that lead to inevitable behaviour pattern. Both young men and women in this study believe that a man has a right or even a duty to, force himself on a woman who displays reluctance and shyness (Leclerc-Malala, 2001).

The components of sexuality are known as the P's of sexuality namely; *practices*, *partners*, *pleasure/pressure/pain* and *procreation*. According to data gathered over the years by Esu-Williams (2000) an additional P of sexuality is revealed and that is the most important of all, and that is *power*. The power underlying any sexual interaction determines how all the P's of sexuality are expressed and experienced. Power determines whose pleasure is given priority and when, how and with whom sex takes place.

The unequal power balance in gender relations that favours men, translates into an unequal power balance in heterosexual interactions, in which male pressure supercedes female pleasure and men have greater control than women over, when, where, and how sex takes place (Gupta, 2001). Young men and women tend to use cultural norms to explain why it is appropriate for African men to have many partners. In a study of student identities and AIDS in institutions of higher learning in Southern Africa, women students interviewed appeared to speak in a relatively detached manner about what they construed as the 'cultural' and historical expectation for men to cheat (Pattman, 2001)

This socially sanctioned disempowerment places women at greater risk of contracting HIV and contributes to the low profile given to the impact HIV/AIDS has on women, specifically those who are already infected (Sherr et al, 1996). While men make the decision to seek voluntary counselling and testing independent of others, women may feel compelled to discuss testing with their partners before accessing the service, thereby creating a potential barrier to accessing services. HIV-positive women would bear a double burden. They are infected and they are women. With respect to AIDS,

Petros Barvazian and Merson (1990) conclude that women experience a “social vulnerability” related to their generally low status that places them at particular risk for HIV infection.

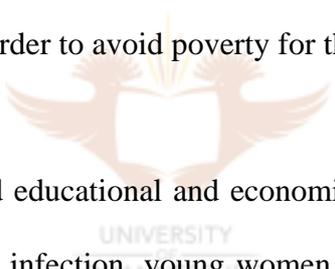
2.4.3 Economic inequality

Women and young girls are believed to be the poorest, most economically marginalised and least educated sector of the South African population. This seems to place them at the bottom of the health pile and renders them particularly vulnerable. (Walker et al, 2004). Tlou (2001) argues that the legal systems and cultural norms of many African countries also seem to reinforce gender inequality by giving men control over productive resources such as land. For example, marriage customs often subordinate wives to their husbands and inheritance customs often make males the principal beneficiaries of family property. In Botswana, a woman married in community of property cannot access credit without her husband’s permission, whereas the husband can without permission from his wife. Such restrictions have far reaching consequences for the rights of women, the achievement of national development and the transmission and rapid spread of HIV/AIDS.

Young women face discrimination in employment and in economic opportunities in virtually every African society, resulting in feminisation of poverty, and perpetuating women’s economic subordination to men (Tlou, 2001). Furthermore, there are laws that limit women’s ability to enter into independent contracts or obtain credit in their own names. Economic dependence on men further limits women’s sexual negotiating power and makes it difficult for women to refuse unsafe sex even when they know

that their male partners are involved in risky sexual behaviours that could predispose them to HIV/AIDS infection (Baum et al, 2001).

The current economic crises in many of the less developed African countries have affected the profitability of the overcrowded informal sector in which a majority of young women are engaged in activities such as petty trade, food preparation, gardening, sewing, domestic services, hairdressing, midwifery, and beer brewing. As economic conditions worsen, many young women, especially in urban areas, are compelled to barter sex for survival and to seek occasional sexual partners to help meet their cash needs (Ickovics, Beren, Grigorenko, Duley, Morrill, & Rodin, 2000). Some women also become engaged in commercial sex work, for which there is demand in urban settings, in order to avoid poverty for themselves and their families.



In an environment of reduced educational and economic opportunities, coupled with denial of the dangers of HIV infection, young women may become easy targets for advances of older rich and increasingly higher risk “sugar daddies” men who provide money and goods in exchange for extramarital relationships with younger women who are presumably at lower risk of being HIV infected (Tlou, 2001).

It is this economic vulnerability of women that increases their vulnerability to HIV/AIDS. Gender may affect economic and health care access. HIV related payments and claims in a Michigan study of 204 adults with HIV infection were affected dramatically by gender, irrespective of severity of illness (Hogan, Solomon, Bouknight & Solomon, 1991).

2.4.4 Socio-cultural differences.

Prevention programs have traditionally neglected the role heterosexual African men play in the transmission of HIV. Until recently, men have been almost invisible as part of solution to the HIV epidemic even though it has been obvious that their socialization and resultant behaviours often determine when, how, and to whom the virus is transmitted (Baum et al, 2001;Gupta, 2001; Tlou,2001). It was in the year 2000 that for World AIDS Day many stakeholders realized that men could be enlisted to role model appropriate and constructive masculine behaviours.

The same gender roles and relationship dynamics that increase women's vulnerability to HIV infection also increase the risks for men (Tlou, 2001). This is because of dominant ideologies of masculinity which encourage men to be aggressive and to demonstrate their prowess or virility by having multiple partners and by consuming alcohol and other substances that predispose them to violent behaviour and sexual risk taking.

Research indicates that some men tend to think that it is acceptable to have extramarital affairs, but that they are not necessarily keen on using condoms and would use them only when they do not trust their partner (Marcus, 2001). Such attitudes and behaviours are the root of growing AIDS epidemic particularly in Africa. In many societies in the African context, there is a culture of silence that surrounds sex that dictates that "good" women are expected to be ignorant about sex and passive in sexual interactions (Gupta, 2001).

This makes it difficult for both men and women to be informed about the risk reduction, makes it difficult for them to be proactive in negotiating safer sex. Domestic violence is also widespread (Women's International Network News, 2002).

In other African countries, studies reveal that more than 40% of women have been assaulted by their male partners. In population based studies, anywhere from 10 % to over 50% of women report physical assault by an intimate partner. One third to half of physically abused women also report sexual coercion (WINN, 2002). Violence against women contributes both directly and indirectly to women's vulnerability to HIV (Gupta, 2001).

According to WINN (2002) in many African cultures, including South Africa, the premium placed on having children often leads to teenagers getting marriage and early childbearing (WINN, 2002). Sherr et al (1996) argues that much of the attention is focused on the woman, with scant attention paid to her partner who may be affected, may possibly be the source of her infection, and who also has a key role to play in future planning for the baby. Fathers are often so overlooked in the HIV area that they are rarely consulted, tested simultaneously or involved in any safe sex dialogue.

This is an enormous shortcoming because male to female transmission is more probable than female to male and given the fact that social support and the family nature of HIV infected person are fundamental elements in coping with, and adjustment to, this life threatening condition (Van der Velde & Van Plight, 1991).

The impact of HIV/AIDS on the African community's economies and social structures is immense. However, there are some particularly gender-bound consequences that deserve to be mentioned. Women often discover their HIV status or suspect that they are infected by chance, a woman's spouse or child may be symptomatic or she may be pregnant and therefore counselled on HIV diagnosis may be the first indication in that woman that her spouse has had another partner and this disclosure is usually very traumatic (Tlou, 2001).

2.4.5 The issue of stigma

Women are usually wrongly accused of having brought HIV infection into the family. This is especially true if a woman goes for testing first or develops noticeable symptoms earlier than her partner does. Fear of social stigmas, physical harm, isolation and, abandonment by loved ones, family and friends often compel women to keep their HIV positive status a secret until very late hour (Klevens, Diaz, Fleming, Mays & Frey, 1999).

In most patriarchal societies, South Africa included, male conduct is determined partly by widely held perceptions as to how male should behave. Women also share these perceptions that males are brave, emotionally strong or at least must appear to be (Leclerc-Malala, 2001; Van Dyk & Van Dyk, 2003).

Mohlahlane (2004) alleges that there is often tolerance of predatory, violent sex, as well as double standards where women are blamed or thrown out for infidelity (real or suspect), while men are expected or allowed to have multiple partners. Research on

HIV/AIDS stigma reveals a gender paradox (Esu-Williams, 2000). HIV/AIDS is still associated with sexual misbehaviour and promiscuity.

While it is almost universally acknowledged and accepted that men are much likely to have had multiple sex partners, society's disapproval somehow ends up on the heads of women rather than men. (Marcus, 2001.) HIV positive women face stigmatisation and are more likely than men to be blamed, stigmatized and abandoned by their families (WINN, 2001).

Green (1996) conducted a study in which he assessed whether there were gender differences in terms of stigma associated with HIV/AIDS among women and men living in the United States of America. The sample for this study was 65% women and 35% men. Findings reveal that women clearly felt more stigmatized than men. The literature suggests that this may be a result of women's greater sense of isolation or because services for HIV tend to be orientated toward gay men rather than women. Moreover, mothers tend to suffer blame and stigma when infants or young adult children become HIV infected.

Community stigma, along with lack of community education and poor communication between couples is exerting a powerful impact on women infected with HIV/AIDS (Esu Williams, 2000). Evidence from Green's study (1996) indicates that stigma among women is more related to women's child caring role. Stigmatisation experiences are frequently reported in the context of motherhood or being in the company of children and therefore have greater impact on women as their social role is far more child orientated than men.

Green (1996) further examined the extent to which there is evidence to suggest gender differences in the social relationships of men and women with HIV/AIDS. This study indicates that disruption to social relationship and stigma including that associated with children seems to affect both sexes. Men and women also seem to face similar issues regarding disclosure of their HIV-positive status. Green (1996) argues that though women and men might be faced with similar issues where the issue of stigma and disclosing are concerned, the social roles generally ascribed to men and women are most likely to cause the impact of an HIV diagnosis may vary as a result of gender differences in social roles ascribed to men and women.

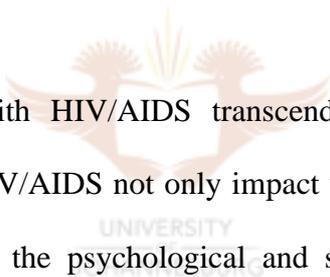
Studies regarding the issue of stigma also indicate that women with HIV as do women in the general population have larger and more supportive networks than men. Good social support is generally perceived to be supportive and beneficial to the mental health of people with HIV (Green, 1993; Hays, Turner and Coates, 1992, 1993; Shabalala, 2001). According to literature, the impact of HIV on social relationships varies according to a range of socio-cultural characteristics. The analysis of data presented in Green's study suggest that differences between men and women with regard to the impact of diagnosis upon social relationships are related to gender, rather than socio-economic differential routes of transmission between men and women (Green, 1996).

In a study of 250 women and 190 men conducted by researchers in Botswana and Zambia in collaboration with researchers from international Centre for Research on women both men and women expressed concern for women who test HIV positive because they felt that men would be likely to abandon an HIV positive partner (Tlou,

2001). On the other hand, both men and women in the study indicated that it was expected that women would initially get angry with an HIV positive partner but ultimately accept him.

The diagnosis of HIV infection has been seen to take a serious emotional toll on men. While women might confide in a mother, a friend or a sister about their HIV status and receive needed support, men may be less likely to do so. The resultant lack of emotional support for men exacerbates their isolation and self pity and may even predispose them to committing suicide (Tlou, 2001).

2.4.6 Gender differences in psychological ramification of HIV/AIDS



The problems associated with HIV/AIDS transcend the medical diagnosis and treatment of the infection. HIV/AIDS not only impact upon the biomedical field, but will also significantly affect the psychological and social realities of any person touched by the virus. Therefore, the health and sense of well being of individuals affected by HIV/AIDS are not dependent solely on the achievements of biomedicine.

The psychological reaction to the diagnosis is the initial influence that knowledge of HIV infection has on the individual's life. Both men and women irrespective of whether the woman is pregnant or not experience many wide spread psychological sequelae of HIV infection. Yet few studies have examined these systematically (Kennedy, et al 1995; Smith & Moore, 1996). As with most areas of understanding, much literature on psychological ramifications of HIV/AIDS is based on large studies of gay men (Sherr, et al 1996)

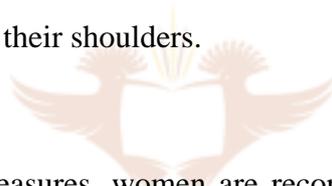
While there is little reason to believe that women's range of emotional reactions would differ, their manifestations, triggers and coping strategies may not be the same. Sherr, et al (1996) argues that within subgroups of women, who may well show extreme and diverse variation, there has been little focus on lesbians and a tendency to group heterosexual men and women as a whole rather than to explore and understand their potential diversity. Many of the issues which are particular to HIV- infection have a bearing on the psychological well being of the individual infected (Schonnesson, 2002). These include stereotyping and marginalization which researchers demonstrate is quite prevalent amongst African women.

HIV/AIDS is still associated with sexual misbehaviour and promiscuity, and society's disapproval especially in the African context ends up on the head's of women and they bear the burnt of the blame (Esu Williams, 2000; Gupta, 2001; Women's International Network, 2001; Buseh, Glass and McElmurry, 2001). Other issues may include reaction to the terminal nature of infection, prolonged adjustment reactions, anxiety, obsessions, feelings of anger and guilt, social stigmatisation and interpersonal problems (Jordaan, 1995).

Most knowledge of psychosocial ramification of HIV again emerges from comprehensive studies of gay men. The extent to which these findings are relevant or can be generalized to women is unclear, resulting in a lag in understanding and corresponding inadequate and unsuitable care. Nilsson Schonnesson (2002) argues that people in research usually refer to men, when in fact they are referring to gay men making it difficult to generalise such findings to all men. Although HIV infection rates among women continue to accelerate in the world and the lives of many women

with HIV infection are dominated by complicated realities, there is an embarrassing void of studies regarding the gender-specific psychological, sexual and social situation of women with HIV infection.

Sherr, et al (1996) postulates that such neglect may well increase the risks of women generally and in particular to socially vulnerable women. The latter may carry the double burden of societal rejection and enhanced vulnerability. Such women may also be jeopardized by relatively weak voices in politics, policy, care and power. It is thus vital that any attempt to create services to provide for the psychosocial needs of women with HIV infection or at risk of acquiring HIV infection must involve an understanding of broader psychosocial functioning of such women, their roles and the burdens that society heaps on their shoulders.

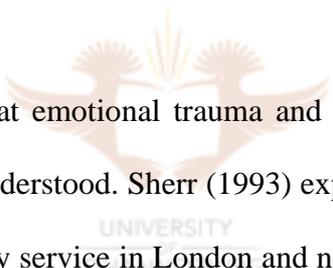


Across most adult mental measures, women are recorded as suffering from greater levels of psychological problems than men (Freeman, 2003; Van Servellen, Sarna & Jablonski, 1998b). This could be explained by the fact that women are more likely to report emotional trauma than men, despite it being experienced by both. Sherr, et al (1996) posits that doctors may be more willing to label emotional states in women than men, admit them to hospital, and refer them to mental health specialists and to prescribe medication.

Equally, the differences may reflect the fact that women's lifestyle have a greater susceptibility to emotional burden with demands of childrearing and homemaking (Nilsson Schonneson, 2001). There is no definitive explanation for the finding, but there is no reason to believe that such gender differences will not be present when

HIV/AIDS are at issue.

Mental health considerations extend from early on in the disease at the time of HIV testing, through disease progression, illness and death. Gender differences can be clearly monitored in the area of HIV testing and counselling, procedures which formed the cornerstone of HIV monitoring, treatment and prevention. Counselling at the time of the test not only prepares individuals for positive test outcome, helps them decide whether they want to embark on the testing process, and addresses risk exposure and behaviour irrespective of whether they proceed to have a test, but also creates an opportunity for the gaining of full and informed consent (Nilsson Schonneson, 2001).



Sherr, et al (1996) asserts that emotional trauma and mental health implications of HIV for women are poorly understood. Sherr (1993) explored all 135 women referred to a specialist HIV psychology service in London and noted attendance late in disease course, low outpatient uptake, high levels of suicide attempts, disturbing issues of rape, common experiences of multiple bereavement, irregular appointment keeping and major problems surrounding confidentiality.

The frequency of suicidal behaviours and thoughts within HIV infected population are also believed to be high. A study by Hegde (1990) compared a population of HIV infected individuals with that of alcoholics in terms of suicidal ideation. It was found that the risk of suicide is nine to 22 times higher than that of the general population. Research found no significant difference in suicidal thoughts and behaviours between these groups, which may suggest that HIV/AIDS infected population has a high risk

of suicide (Hedge, 1990).

According to Jordaan (1995) the relative risk for suicide in men with HIV/AIDS aged 20 to 59 is 39 times higher than of this age group without diagnosis and 66 times than that of the general population. This could be attributed to avoidance coping strategies and deprivation of social support which is associated with high suicidal ideation.

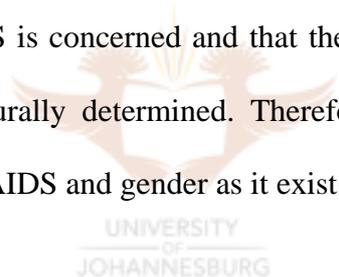
Anxiety and depressive reactions are commonly documented in men and women with HIV disease along with associated panic attacks, heightened arousal, and misinterpretation of physical symptoms, social disengagement, mood swings and isolation (Miller, 1990). Depression can entrench strained relationships and result in loneliness. This is particularly severe when secrecy shrouds diagnosis. For some women multiple infections can suppress their mood, especially if their partner and their child is also HIV positive. Depression can be affected by grief, loss and bereavement, which multiply in case of HIV disease (Sherr, et al 1996).

Data suggest that women with HIV have substantially higher rates of depression than their male counterparts (Ickovics et al, 2000). Another consistent finding is that depression is associated with physical symptoms and not with laboratory markers (Roberts, 2001).

In the case of South African women, concern over their children and other dependents may contribute significantly towards the incidence of anxiety, as well as the implied threat contained in self disclosure and possible societal ostracisation.

Grief may be particularly difficult to accommodate if the loss was due to AIDS given that the partner/spouse may have witness the mode of her own demise in losing the person who may have given her comfort and care. The whole course of disease may be punctuated with bereavements, from loss of life expectancy, to actual death, to health, future aspirations and childrearing. Given such a scenario, suicidal behaviour may well be an issue (Sherr, 1995; Starace, 1995).

In the United States of America mental health resources provision is limited and often male focused among those who are HIV positive, despite the particular needs of women especially when several family members are infected (Sherr, et al 1996). The above discussion clearly indicates that there seem to be major gender differences in as far as the issue of HIV/AIDS is concerned and that these differences are not natural but rather socially and culturally determined. Therefore, the following discussion focuses on the issue of HIV/AIDS and gender as it exist in the South African context.

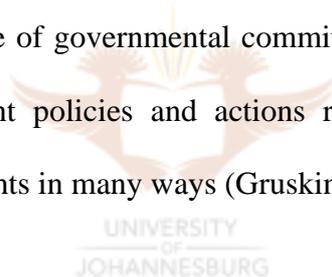


2.5 POLITICAL CONTEXT WITHIN WHICH HIV/AIDS AND GENDER ISSUES EXIST

It is significant to view HIV/AIDS within a political context and in this regard the South African political context. In the broader context of Africa, which includes widespread poverty and unemployment, particularly amongst women, a history of men crossing national boundaries in the battles for independence or other military actions, social disasters and the increase in intra Africa economic exchanges, which are based on colonial patterns of production reinforced by uneven regional investment in the global economy is heavily incriminated in the spread of HIV/AIDS (Susser &

Stein, 2000).

Over the past several years, Sub Saharan African governments have devoted increasing attention to HIV/AIDS in their reporting of progress on implementation their human rights obligations to relevant human right bodies (Gruskin & Maluwa, 2002). A major human rights problem in the context of HIV/AIDS is discrimination against those known or perceived to HIV infected and those affected by HIV/AIDS, as well as discrimination against others that leads to denial of access to entitlements and services and increases vulnerability of HIV/AIDS. Each of the major human right treaties specifically sets out the principle of non discrimination with respect to certain categories such as age, race, gender, colour, language, political or other opinion, social origin or birth. In spite of governmental commitments and increased attention to human rights, government policies and actions relevant to HIV/AIDS fail to adequately protect human rights in many ways (Gruskin & Maluwa, 2002).



Grundlingh (2001) notes that in South Africa HIV/AIDS became known during the Apartheid regime. According to Grundlingh (2001) HIV/AIDS was also viewed as a homosexual disease, a disease of drug users and later as a disease of Black communities. Therefore the history of HIV/AIDS in South Africa is rooted in a framework couched in a discourse of deviancy and scapegoats and thus there was no urgency in addressing this infection.

It exposed and intensified social prejudices, stereotypes and economic inequalities, discriminatory practices and political injustices (Grundlingh, 2001). Furthermore, the involuntary migration associated with men's employment far away from home which

was enforced by the previous Apartheid regime which was also experienced by many families in rural and semi-rural areas, is associated almost inevitably with causal and extra-marital sexual encounters (Susser & Stein, 2000).

As a result of these factors, extra-marital sex is frequent amongst men and widely tolerated, if not necessarily enjoyed by women. Like so many other infectious diseases, HIV/AIDS is a disease of poverty and South Africa's history of inequality and social dislocation must have contributed to the severity of the epidemic. HIV/AIDS prevention programs cannot address these broader complexities directly, but they must take cognisance of this context within which the infection is spread (Harrison, Smith & Myer, 2000).



The South African government initiated a number of strategies deemed useful in educating the public about the danger of HIV/AIDS and condoning the notion of prevention since the beginning of the pandemic. However, the effectiveness of those initiatives remains a mystery given the fact that more and more people are becoming infected daily. Due to conflicting findings regarding issues of treatment and the serious side effects that such treatment can incur on those who are infected, the South African government decided to explore other alternative treatment methods such as, encouraging those infected with HIV to consume more vegetables in order to boost their immune system. This move by the South African government caused a huge controversy both nationally and internationally.

According to Stine (2004) this political stance caused scientific uproar in South Africa fuelled largely by dissidents' theories on HIV/AIDS and the seeming support of

President Mbeki has much broader implications for South Africa and South Africans than some are prepared to admit. The controversy somehow seems to be undermining the constructive public health messages the government has put in place. Stine (2004) argues that undermining scientists and the scientific method is especially dangerous in a developing country still in the process of establishing strong scientific research base.

In July 2003, the South African Cabinet decided to develop a plan to make antiretroviral drugs available to people with HIV infection. In developing their plans, they worked on the assumption that treatment should be made available to people with CD4 count below 200 cells and that clinical conditions would also affect whether individuals were recommended for antiretroviral. Stine (2004) postulates that even in its most limited, this treatment plan will be the largest developing world treatment program within three to four years and in its most comprehensive form could treat over a million people by 2008.



2.6 CHAPTER SUMMARY

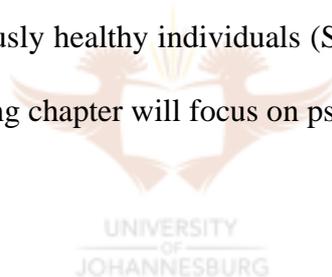
Since its inception in 1983 when scientists first isolated the human immunodeficiency virus (HIV) there is no doubt that the profound global consequence of the HIV pandemic on humanity during the last decade of the twentieth century will be important to history. This chapter attempted to demonstrate how broad and complex the manifestations of HIV/AIDS are and the challenges it presents to those infected.

Furthermore, gender differences as they relate to power relations, socio-economic inequality and psychosocial differences were explored. These differences also appear

to add to the already complex nature of HIV/AIDS another dimension that may further compromise the disease progression and survival of those infected with HIV/AIDS.

An HIV-positive notification may evoke a myriad of emotions that may become a major source of stress and anxiety exacerbated by a threat of one's impending death.

A study by Steven & Doerr (1997) revealed that the discovery of being HIV-positive is a traumatic event carrying with it elements that are common to other types of trauma such as fear, helplessness and perceived threat to one's life. There has been a consistent recognition that traumatic incidents can induce profound emotional and physical symptoms in previously healthy individuals (Schnurr & Green, 2004). In the light of the latter, the following chapter will focus on psychological trauma.



CHAPTER THREE



PSYCHOLOGICAL TRAUMA

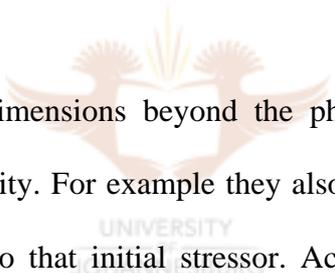
3.1 INTRODUCTION

There has been a consistent recognition that extreme events can induce profound emotional and physical symptoms in those exposed to them. Numerous studies have shown that trauma exposure has substantial and diverse effects on many aspects of well being, such as an increased likelihood of depression, substance abuse and most psychiatric disorders (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). Most research into physical health effects of life events has not included traumatic stressors. For example, a review of literature in stress and infectious diseases in human suggested that the “impact of severe events would provide the fairest test of the stress-disease relationship” (Cohen & William, 1991 p110-111). It is in the light of the latter that a discussion to follow attempts to explore the issue of trauma as it relates to impact that finding out one’s HIV-positive diagnosis may have on the person.

Few phenomena are as widely experienced across different individuals, cultures and context as that of traumatic stress. Whether as victims, perpetrators, supporters or simply observers, most if not all people can identify to some extent with the psychological and physical consequences produced by traumatic events (Pauwels & Harvey, 2000).The consequences of traumatic events, while certainly devastating for

the most immediate victims are also experienced by the people in the social network that surrounds those victims.

Despite the widespread and often personal relevance it has for most people, the issue of traumatic stress has only recently emerged as a cohesive, identifiable area of interest for most theorists, researchers and practitioners (Pauwels & Harvey, 2000). Pauwels & Harvey (2000) further assert that the contexts in which traumatic events occur can be studied in numerous ways. The specific nature of a given traumatic event can raise unique challenges for the victims who endure the event, the scholars who attempt to understand the event and the practitioners who assist in the event's aftermath.



Traumatic events vary on dimensions beyond the physical stressors that initially produce discomfort or disability. For example they also differ in the extent to which cultural contexts contribute to that initial stressor. According to Bryant & Harvey (1998) traumatic events also vary in terms of the immediate and long-term consequences of the event, both for the victims and those close to them.

Finally, the nature of trauma often dictates both the opportunities and obstacles faced by researchers and practitioners who seek to understand or intervene after the event occurs. Therefore in this study, a Person-environment approach to traumatic stress reaction will be utilized and will also incorporate all the above to provide a more holistic approach to trauma.

In the section to follow the focus will be on the meaning of trauma, the historical background thereof and how it is perceived in different contexts.

3.2. BRIEF HISTORY OF TRAUMA AND DEFINITIONS

As early as the end of the nineteenth century, the fascination of the consequences of shocking events on people has not escaped the exploration of scientists (Kleber, Figley & Gersons, 1995). This intrigue in the subject became even more prominent after the disastrous World Wars in the first half of the twentieth century. During World War II, psychologists became especially interested in stress and its effects on thoughts, actions, and physical well-being (Baron & Byrne, 2000). Finally, in more recent decades and after the attention focused on the effects and consequences on soldiers combating in the Vietnam War (Westen, 1996), the concept of trauma made an official entrance into the fields of mental health and the social sciences with interest in trauma escalating from around 1980 due to the introduction of the diagnostic concept of posttraumatic stress disorder (Kleber, Figley & Gersons, 1995).

The word 'trauma' originates from the Greek language and means 'hurt' or 'wound' (Louw, 2001). The Oxford Advanced Learner's Dictionary defines trauma (psychological) as an emotional shock producing a lasting harmful effect, or an unpleasant experience that causes distress or anxiety for the individual (Crowther, 1995). This understanding is in line with most conceptualisations of trauma, including that of Louw (2001) who suggests that trauma is an emotional shock that creates significant and enduring damage to the psychological development of the individual.

McFarlane (1995) conceptualises trauma by pointing out its central characteristics, namely, the experiences of helplessness, powerlessness, and the threat to one's life and sense of control. Baron & Byrne (1997) define trauma similarly that is, as the perception of personal, physical or psychological threat, and stress as the responses elicited by trauma. Traumatic stressors are thus not limited to exposure to a traumatic event alone, but include the degree of perceived risk of exposure to traumatic events (Sorenson, 2002). Zlotnick (1997) also quotes that others define trauma as an unpredictable crisis that is out of the range of normal experience, beyond personal control, and destroys emotional equilibrium long after the event has passed.

Trauma was also first introduced in the Diagnostic Statistical Manual-III (DSM) as a catastrophic stress in most people. Trauma was characterised as a rare and overwhelming event that differed qualitatively from "common experiences such as bereavement, chronic illness, business losses or marital conflict" (Friedman, 2003 p34-35). Traumatic events cited in the DSM-III included rape, assault, torture, incarceration in a death camp, military combat, natural disasters, industrial/ vehicular accidents, or exposure to war/ civil/domestic violence. Although the list of potential traumatic events has changed little since 1980, Friedman (2003) asserts that our understanding of trauma has changed significantly, particularly in relation to the prevalence and psychological impacts of catastrophic events. Specifically;

- Catastrophic events are not rare. Research in the United States indicates that over half of all American men (60.7 %) and women (51.2%) will likely be exposed to at least one catastrophic event during their lives (Bisson, McFarlane & Rose, 2000). Exposure prevalence is obviously much higher in

countries torn by war, civil strife, genocide, state-sponsored terrorism, or other forms of violence.

- Trauma is not just an external event. The concept of trauma has changed from a rare, external event (as defined in the DSM-III) to an individual's psychological response to an overwhelming event as defined in DSM-IV-TR (Friedman, 2003).

Initially researchers thought that trauma could be defined exclusively in terms of catastrophic events that happened to individuals who were in the wrong place at the wrong time. As initially conceptualized, anyone exposed to war, rape, torture or natural disaster would be traumatised. This approach changed in the 1994 Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition because most people exposed to catastrophic events failed to develop PTSD.

Although exposure to catastrophic stress is a necessary condition, it is insufficient by itself to traumatise an individual. The critical discriminator is the person's emotional response to such an event. If the rape or incident produces an intense emotional response characterized in the DSM-IV-TR as fear, helplessness, or horror the event is traumatic (American Psychological Association, 2000). If an event does not produce an intense emotional response, then the event is not considered a traumatic event and, according to the DSM-definition, cannot cause PTSD.

Until the DSM-IV, there was no diagnosis that could be given to an individual who may have suffered great distress during the immediate aftermath of a traumatic event, but who recovered within a month's time. For example, prior to inclusion of Acute

Stress Disorder (ASD) in the DSM-IV, military psychiatrists named such acute reactions as combat stress reaction or battle fatigue. ASD now appears in the DSM IV for two reasons:

- To recognise the significant levels of distress experienced in the initial month following a traumatic experience
- To foster early identification of those trauma survivors in the greatest distress (Ehlers & Clark, 2003).

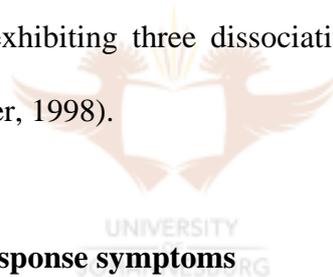
3.2.1 The difference between Post traumatic stress disorder (PTSD) and acute stress disorder (ADS)

Most people exposed to a traumatic event experience considerable distress. Such reaction is usually a normal, temporary response from which recovery is complete. When the response is severe, incapacitating and characterised by nightmares, pathological avoidance and other symptoms such as numbing, dissociative amnesia and reduction in awareness individuals may meet diagnostic criteria for acute stress disorder (Horowitz, 1986). ASD can only be diagnosed within the first month after traumatic event. If symptoms persist beyond one month, the client may meet the criteria for Post Traumatic Stress Disorder (PTSD).

ASD symptoms for the most part are similar to those of PTSD however, an individual need only exhibit one each of the re-experiencing such as recurrent distressing dreams, recurrent and intrusive distressing recollections of the event including images, thoughts or perceptions, avoidant and hyper- arousal symptoms which include efforts to avoid thoughts, feelings or conversations associated with the trauma, efforts

to avoid activities, places or people that arouse recollections of the trauma, difficulty falling asleep, irritability, hypervigilance and exaggerated startle response to be diagnosed with ASD. Individuals must exhibit more symptoms from these clusters over a longer period of time before diagnosed with PTSD (Friedman, 2003).

The major difference between ASD and PTSD is the greater emphasis placed on symptoms of dissociation in ASD. With dissociation, normal mental functions such as memory, sense of time, or sense of one's body or personal identity as a coherent entity, may be severely distorted. Dissociative symptoms must present in ASD but not in PTSD. Acutely traumatised individuals need exhibit only one symptom from the re-experiencing, avoidance and hyper-arousal clusters, however, meeting ASD diagnostic criteria requires exhibiting three dissociative symptoms (Marks, Lovell, Noshirvani, Livanou & Thraser, 1998).



3.2.2 The course of stress response symptoms

According to Horowitz (1999) there is a definite course of stress response symptoms. The first set of response is that traumatic events are usually repressed and yet involuntary repeated in the form of hysteria symptoms. While some reminiscences of their hysteria patients stemmed more from fantasy than from reality, the central observation of compulsive repetition of trauma was validated in many clinical field and experimental studies.

The second common set of stress responses includes ideation denial and emotional numbing. These signs seem antithetical to intrusive repetitions and are regarded as a

defensive response (Horowitz, 1999). Tendencies to both intrusive and denial-numbing occur in populations that vary in predisposition after stressful events that vary in intensity and quality and may occur simultaneously in a given person or pattern of phasic alteration.

Therefore there is a common pattern to the progression of phases of stress response. With the onset of the traumatic event, especially if it is sudden and unanticipated, there may be emotional reactions such as crying out or a stunned uncomprehending gaze. After these first emotional reactions and physical responses, there may be a period of comparative denial and numbing. Then oscillatory period emerges wherein there are episodes of intrusive ideas or images, attacks of emotion or compulsive behaviours alternating with continued denial, numbing and other indications of efforts to ward off the implications of the new information (Horowitz, 1999).

Finally, a phase of working through may occur in which there is less intrusive thoughts and less uncontrolled attacks of emotions with greater recognition, conceptualisation, stability of mood and acceptance of the possible meaning of the event (Horowitz, 1999).

Clinicians working with trauma patients caution that extra sensitivity and respect is needed when assessing clients with ASD, since PTSD clients have a chronic condition to which they have had an opportunity to adapt, whereas ASD clients have been acutely traumatised and therefore, find themselves in an intense, novel and extremely disturbing psychological state that they usually cannot comprehend (Bisson, McFarlane & Rose, 2000). Hyer (1994) identifies seven different theoretical

approaches to dealing with trauma including learning theory approaches, biological theories, psychodynamic theories, psychosocial theories, ecosystemic theories, constructionist as well as information processing approaches.

This study concerns itself with an interactional model of traumatic stress reactions which is systemic in nature. It attempts to specify how excessive stress is likely to alter personality functioning in pathological or non pathological ways (Wilson, 1989).

3.2.3 A potential framework for a theory of traumatic stress reaction

Freud (1957) maintains that traumatic events occur inside the psyches of individuals. The subjective experience of a traumatic event varies from person to person and from one event to another. It is also the case that there are levels of objective severity to traumatic events and it is possible to conceptualise stressors as falling along a continuum of stressfulness of different dimensions, such as the threat to life and physical integrity to a more purely psychological focus, for example, the witnessing of an atrocity or the infliction of harm to a loved one. As noted in DSM-III traumatic events can either be man made or the result of a natural disaster or environmental event (APA, 1987).

There is consensus among researchers that individuals' different variables, such as personality traits, cognitive style, gender and intelligence affect and influence the way in which stressful events are perceived, appraised, and processed (Horowitz, 1979; 2001, McFarlane, Atchison, Rafalowicz & Papay, 1994, Raphael, 1986.). Further, traumatic events are never culture free and it is important to understand how cultural

differences affect how a person perceives, interprets, and assimilates such experiences. In the following section the focus will be on Wilson's interactional model of traumatic stress reaction and all that it entails.

Wilson (1989) posits that as a general principle, an interactional theory assumes that;

- Individuals with differing personality propensities seek out reinforcers from situations, including traumatic ones that will gratify their prepotent needs states (Aronoff & Wilson, 1985).
- The propensities of the person interact in a dynamic way with the environmental and situational elements of the traumatic stressor to set up both individual subjective reactions to the trauma and
- Patterns of post traumatic adaptation which can be acute or prolonged in nature.



The above elements by Wilson will be briefly discussed respectively to provide a more comprehensive understanding of how each interacts with other processes to influence the way in which trauma is experienced.

3.2.3.1 Person variables

An interactive theory of traumatic stress recognises implicitly the importance of personality variables in determining reactions to traumatic events. These personality dimensions include the major variables studied by clinicians and researchers in the field of personality and social psychology namely; motives, traits, beliefs, values, abilities, cognitive structure, mood and coping styles, as well as genetic propensities

(Wilson, 1989). Arnoff & Wilson (1985) postulate that personality traits are directly associated with cognitive styles of information processing, especially in the acquisition, processing and goal setting dimensions of encoding information from situations.

Therefore when the personality characteristics of the individual are organised around safety-oriented needs (i.e., insecurity, anxiety, dependence, authoritarianism, approval seeking etc), the cognitive style of information processing under conditions of stress is more likely to result in a tendency toward the reduction or constriction of information from the stimulus field, which in turn, directly affects the processing of encoded information and formulation of a schema for enactment.

On the other hand, personality characteristics concerned with enhancing self esteem and competency (i.e., need for achievement, dominance, internal locus of control, nurturance) tend to be associated with a cognitive style that increases and expands the search for the stimulus field under conditions of stress (Wilson, 1989). As a result, there is vigilance in processing the material encoded which can lead to effective problem solving or excessive hypervigilance, depending on how the stressor was perceived and initially appraised during the trauma.

According to the interactionist perspective of traumatic stress personality processes affect and dynamically interact with all the four categories of environmental variables (stressor attributes, experience of trauma, structure of trauma and post trauma milieu) to influence the specific nature of the individual subjective response to the trauma (Wilson, 1989). Theoretically, it is possible to suggest that many different personality

dimensions could be crossed with the four environmental dimensions (stressor attributes, experience of trauma, structure of trauma and post-trauma milieu) to create a matrix of predictions regarding the five dimensions of individual subjective response and different forms of post trauma-adaptation (Bisson et al, 2000).

3.2.3.2 Environmental and Situational variables

Traumatic events differ on many different dimensions. Wilson (1989) identifies these dimensions as follows;

- The degree of life threat
- The degree of bereavement or loss of significant others
- Imminence or rate of onset and offset of the stressors
- The duration and severity of the stressors
- The levels of displacement and dislodging of persons from their community
- The exposure to death, dying, injury, destruction and social chaos
- The degree of moral conflict inherent in the situation
- The role in the trauma (agent versus victim)
- The location of the trauma (home versus elsewhere)
- The complexity of the stressor (single versus multiple)
- The impact of the trauma in the community (e.g. a natural disaster)

Traumatic events can be classified according to the levels to which the latter dimensions exist in the trauma. The more these dimensions are present in any particular trauma, the greater the potential for producing a pathological outcome

(Breslau, Davis, Andreski & Peterson, 1991, Cooper & Watson, 1991; Ehler & Clark, 2003; Horowitz, 1991; Norris, 1991; Ulman & Siegel, 1994). However, consistent with the general principle of an interactional theory, personality and situational variables will interact with the stressor dimensions in determining whether a person would be traumatised or not and the possible post-trauma adaptation (Wilson, 1989).

Finally, each of these stressor dimensions can be linked to post traumatic symptomatology independent of the personality traits of the person that might moderate different outcome processes (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995).

3.2.3.3 Individual subjective response to trauma

Recent research on trauma has placed greater emphasis on a person's subjective experience and response to trauma than on the severity of the stressor itself (Davidson, 1995; Fontana & Rosenheck, 1997; Horowitz, 2001). Although posttraumatic stress symptoms were once thought to be directly proportional to the severity of the stressor, empirical studies have shown otherwise.

Individual subjective response to trauma refers to the initial responses that occur in the wake of stressful experiences. McFarlane (1995) writes that the central characteristics of traumatic stress include the experiences of helplessness, powerlessness and a direct threat to an individual's sense of control as well as their life.

Wilson (1989) alleges that there are five separate but related dimensions to adaptive behaviour, which can be classified as:

- Emotional
- Affect
- Cognitive
- Motivational
- Neurophysiological

These will now be discussed individually.

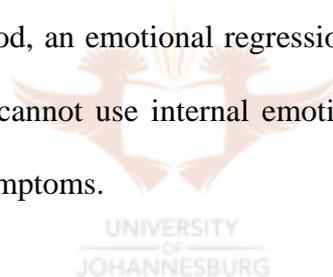
3.2.3.3.1 Emotional dimension

By their very nature traumatic events upset the psychic equilibrium of individuals affected by them. Traumatic events inevitably produce powerful emotional reactions in persons because they disrupt normal homeostatic functioning on the physiological level (Friedman & Schnurr, 1995; Wilson, 1989; Wilson & Keane, 1996). Persons vary in how they subjectively experience and cope with the excessive autonomic nervous system arousal and endocrine secretions triggered by threatening and overwhelming traumatic experiences.

Wilson (1989) postulates that in affective distress, the person feels overwhelmed, emotionally, fearful, flooded with distressing affect, extremely anxious, and may be unable to mobilise intellectual and personal resources to effectively solve problems in the face of what has happened. Alternatively some people shut down emotionally when confronted with an intense and upsetting event and experience affective numbing, a state in which the capacity to feel is greatly reduced (Blake, Charney,

Nagy, Kaloupek, Keane & Weathers 1995). Andrews & Brown (2000) theorise that anger may be a core component of the instinctual survival of response of an individual when he or she is threatened. However, should anger persist in the absence of an existing external threat, then it can be maladaptive. Anger prevents feelings of anxiety that in turn impedes the natural processing of threatening feelings which are needed for eventual psychological adjustment (Qualls, 2002).

Lifton (1988) suggested that when affective numbing is reduced, alleviated, or suddenly “lifted” by failure in ego defences, the person may experience affective forms of vulnerability or a fear of loss of control. Wilson (1989) asserts that if psychic trauma occurs in childhood, an arrest of emotional development frequently results. If the trauma occurs in adulthood, an emotional regression often occurs. In either case, survivors of trauma usually cannot use internal emotional state as signals and may experience psychosomatic symptoms.



Researchers add that they also become incapable of soothing themselves when under stress. Herman (1992) reports that posttraumatic symptoms are more likely to be experienced when the individual is under stress, however supportive response from the environment helps to mitigate the impact of trauma, whereas a hostile or negative environment compound and aggravate the traumatic syndrome.

3.2.3.3.2 Affect balance

Affect balance refers to the third category of emotional reaction to a traumatic event. As implied by the term, affect balance indicates that the person is able to successfully

modulate affective state, both positive and negative, which naturally occur in unusually stressful situations (Mueser, Goodman, Trumbetta, Rossenberg, Osher, Vidaver & Auciello, 1998). To a large degree, affect balance is a healthy response to trauma and associated with the cognitive ability to realistically appraise what has happened and to respond with instrumental coping which is efficacious in meeting the immediate demands of the situation (Horowitz, 1979; Wilson, 1989).

3.2.3.3.3 Cognitive

The cognitive responses that occur in the immediate and long term aftermath of a trauma refer to modalities of information processing or ways of understanding the event that has occurred (Blake et al, 1995). In an interactional theory of traumatic stress reactions, cognitive processes are especially important because they are multidimensional and include the following perception of the event(s), appraisal of the situation, attributions of causality and a schema for enactment of response.

Wilson (1989) identifies at least five major cognitive styles of information processing that characterise how individuals encode and process the four dimensions as indicated above.

The first cognitive style is cognitive denial or avoidance which refers to the tendency to deny or avoid what has happened by blocking the perception of the event. It also involves appraising the situation as one that does not require help, forming an attribution of causality that minimises responsibility or involvement in the larger context of the situation and leads to a schema for enactment that includes denial,

fantasy, avoidance of situations that trigger reminders of the experience or survivor's guilt for a failed enactment. For example an individual who has strong beliefs about personal control over events may be more likely to deny the fact that a traumatic event rendered him/her powerless and helpless since s/he not control over it (Wilson, 1989).

The second style, cognitive distortion is similar to psychic denial except that the person engages in extensive distortion in perception, appraisal, attribution and enactment. Cognitive distortion is a mechanism that seems to ward off the intense anxiety and fear that the individual experiences so acutely in the immediate context of the vent. Distortion, like denial, is a cognitive style whose effect is to reduce rather than augment internal stimuli. It can be thought of as a safety mechanism which prematurely terminates a search of the stimulus field for additional information that could lead to problem solving behaviour. As a result, there is a high degree of selective attention, narrow search of the stimulus field, an intolerance of ambiguity due to affective arousal and a low level of search persistence for information that pertains to the processes of appraisal, attribution and enactment. For instance a person may attempt to rationalise and intellectualise about a traumatic event in an attempt to distort to ward off fear evoked by the event.

Accurate appraisal is a third cognitive process that is characterised as an information processing ability to accurately perceive what has happened in the trauma, realistically appraise the situation in terms of persons and events involved, make a correct or adequate assessment about causality, and initiate attempt to respond effectively and adaptively. The person who can accurately appraise the nature of

traumatic event is more likely to increase internal stimuli, actively scan the stimulus field, engage in a search of a new or necessary information, and persist in such attempts, since the outcome of this mode of cognitive functioning is the ability to act competently in terms of personal needs and the demands of the situation (Cooper & Watson, 1991).

The fourth cognitive style is dissociation, Lifton (1988) reviewed much of the early thinking about reactions to trauma involved the concept of dissociation. As traditionally conceived, the concept of dissociation refers to an alteration in consciousness, identity or behaviour (APA, 1987). As a cognitive mechanism, dissociation is an alternative way to ward off extreme emotional distress by altering the nature of perception, appraisal, attribution and the schema for enactment.

Lifton (1988) contends that in response to the perception of threat, the individual fears being vulnerable and helplessness and engages in a dissociative reaction which could be an alteration in level of consciousness, the expression of personality, or unconscious behavioural expressions such as fugue states. Similar to denial and distortion, dissociation is a safety oriented cognitive mechanism in which the individual is attempting to avoid situations of conflict or threat that disrupt the psychic equilibrium.

There is an encouraging level of agreement across different psychological schools of theory namely; psychodynamic, cognitive and behavioural learning on how to explain some posttraumatic processes as indicated in the above discussion. These theories concur in use of associational concepts (Horowitz, 1999). A person can forge strong

new connections between bits of memory when experiencing a traumatic event. These include conditioned associations that link perceptual stimuli, such as loud noise from an explosion, with ideas of high danger and emotions of fright (Harris, 1991). According to Harris (1991) and Horowitz (1999) traumatic events also establish vivid emotional and active memories. These memories are coded as high priority for review because they are so threatening to personal well-being. Some reviews are so intense that they feel as though they are reliving the traumatic experience which may then affect the person's psychosocial functioning.

3.2.3.3.4 Motivation

Traumatic events can affect the motivational propensities of a person. Motivational propensities refer to individual differences in the strength of various motives that have emerged from psychosocial development (e.g. the need for affiliation, the power motive, the need for safety and predictability). Wilson (1989) asserts that from the perspective of an interactional theory, these motives may be activated by the trauma or remain dormant. For example, the unexpected death of a loved one may arouse a motive of nurturance and lead to the active initiation of generativity, caring for others, or involvement with organisations or groups with prosocial goal and values.

On the other hand, it is also possible for motives of safety (Arnoff & Wilson, 1985) to be activated and lead to behaviours designed to defend against anxiety by constructing highly predictable structured and ordered activities. Such a phenomenon was observed by Goldstein (1963) in brain-injured individuals and led him to formulate the construct of catastrophic anxiety which the individual experienced when an

expected routine or order disrupted. Finally, it may be the case that traumatic events can either give birth to new motives or transform old motives in new directions. When new motives are born from the trauma, they represent a form of personality alteration, as in the case of psychosocial acceleration in ego development (Wilson, 1980).

The transformation of motives seems to occur when trauma produces a rapid change in the cognitive structure of the person in terms of the organisation of the belief structure. For example, when a great deal of disillusionment is produced by a stressful life event, the person may let go of belief systems that now seem inoperative in light of what has happened (Wilson, 1989). In this process of cognitive disequilibrium, there then emerges a new set of beliefs and values which may facilitate a change in the nature, prepotency and organisation of basic needs.



3.2.3.3.5 Neurophysiology

In terms of individual subjective response to trauma, there are variations in neurochemical and endocrine secretion which result from exposure to traumatic events. Wilson (1989) introduced an overly simplified way these neurophysiological processes can be classified as states of hyperarousal, avoidance, depression and balance. In hyperarousal, it is believed that the catecholaminergic substances of noradrenalin, serotonin, and dopamine are extremely elevated to the point that their use eventually exceeds synthesis and leads to an avoidance cycle. Neurophysiological states can vary in duration, severity, and periodicity depending on their activation by external stimuli or through associative learning. In the extreme form, chronic

activation of the hyperarousal avoidance cycle can be thought of as the neurophysiological substrate of post traumatic stress disorder.

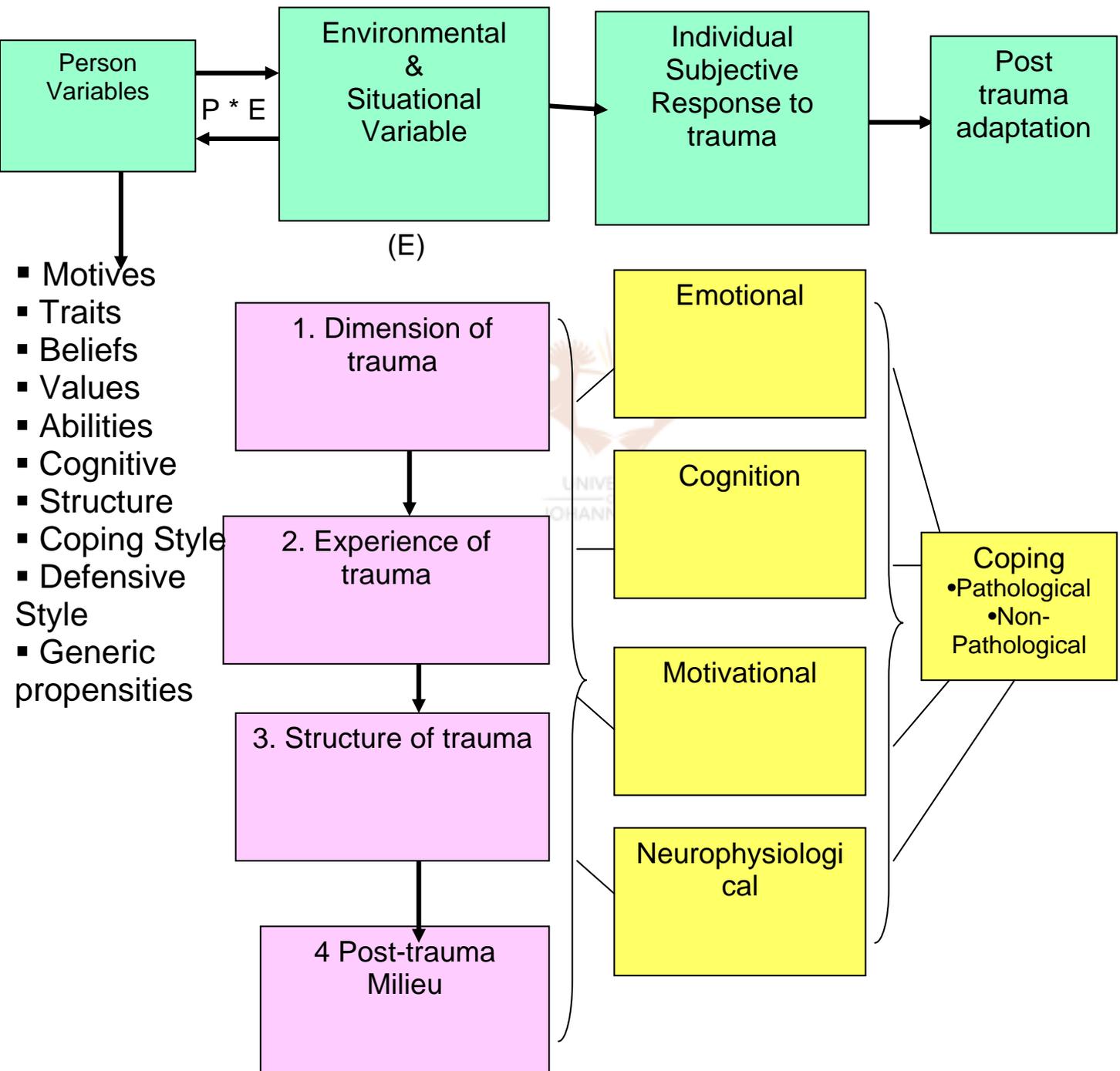
Neurophysiological studies on post trauma reactions were usually conducted in populations formally diagnosed with Post Traumatic Stress Disorder (PTSD). A number of studies reported baseline autonomic activation in PTSD patients characterised by increased heart rate, systolic blood pressure or forehead (Blanchard, Kolb, Pallmeyer & Gerardi, 1982, Pitman, Orr, Forgue, deJong & Clairborn, 1987).

Although Malloy (1983) did not observe this increased heart rate, they did note a larger heart rate increases in PTSD patients than controls in response to neutral stimuli. PTSD patients also exhibited a more marked conditioned autonomic hyperactivity in the laboratory as evidenced by increased heart rate, respiratory rate and galvanic skin response (Blanchard et al, 1982; 1986; Pitman, 1987). Many of these studies also documented conditioned anxiety, agitation and panic states in association with the physiologic measures.

In the following page is Figure 1 which depicts how the various aspects interact as postulated in the above model.

FIGURE: 1 Interactional model of response to trauma

Inputs to the Processing of trauma



In the following section we will focus on trauma and culture and how culture affects how trauma is perceived and accepted.

3.3 TRAUMA AND CULTURE

'Trauma goes beyond the individual. It has a far wider context. We interpret war, loss, violence, and disasters in ways shaped by our culture, by our society, and by its values and norms. We cope with serious life events in ways provided and approved by our surroundings' (Kleber, Figley & Gersons 1995, p56.).

There can be no question that South Africa presents herself as an extraordinarily culturally diverse country. In addition, she is a country that survives in the aftermath of an indescribably cruel history. The road she is on is one of pain, forgiveness, truth, reconciliation, and growth. Sadly too, as she recovers, the evil nature of man and the unpredictable nature of the universe persist, with the result that people remain exposed to traumatic events that alter human lives frequently.

3.3.1 Cultural meaning and context in trauma

As a result of the complexity of the term 'culture', as well as the multiple ways in which the term is applied, there has been a persistently increasing interest in culture and how to define it during the last two decades (Abercrombie, Hill & Turner, 2000). Often viewed as the most localised understanding of culture, the term may apply to groups that have a specific and unique culture in one common sense of the word – for instance, where 'culture' refers to the exclusive customs, perspectives or ethos of a group, such as a 'gay culture' or a 'prison culture' (Kymlicka, 1995). At the opposite

end of the spectrum, however, the term ‘culture’ employs a far more inclusive view to describe modern, secular, industrialised, urban societies – such as the ‘Western culture’. Moreover, the term ‘culture’ is sometimes contrasted with the biological aspects of people by being used as a collective noun for the learned and symbolic aspects of human societies such as custom, language, and convention. It may also be used to collectively describe a way of life where diverse beliefs, attitudes, social structures, institutions, and practices differentiate social groups from each other (Abercrombie, Hill & Turner, 2000).

“Culture represents the internalization of values, customs, morals, and culturally rooted beliefs as well as “rules” pertaining to social interaction and self-presentation” (Wilson, Friedman & Lindy, 2001 p.436). It is not an independent thing but rather what we are as people, guiding us in how we behave; it is an expression of our values and beliefs and is about borrowing and manifestation (Boon, 1996).

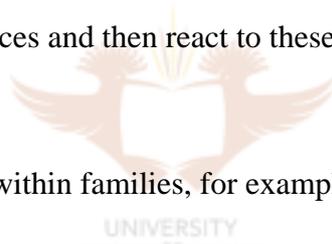


With such vivid descriptions of what trauma encompasses it seems both ridiculous and impossible to attempt to address such intense human reactions without taking into account the very ‘humanness’ or culture of the client. Indeed, literature appears unanimous in the view that traumatic experiences do not escape the influence of social and cultural context. For instance, Radebe (1993) stresses that traumatic events are never culture free and that it is necessary to understand how cultural differences affect the way in which a person perceives, interprets and assimilates such experiences, and ultimately how the individual will react on a behavioural and an emotional level. Indeed, cultural values may influence the way in which an unpredictable event will challenge an individual’s sense of identity as well as the

extent of the sense of violation associated with trauma (McFarlane, 1995). Victims of situations and circumstances control the severity and intensity of consequences of acute life events such as violence, human rights violations, sudden bereavement, disaster and combat, and often even determine the development of the events themselves. Situations as diverse as political repression, combat, abuse and technological disasters are human-made and confront the individual with feelings of despair, helplessness, powerlessness and disruption. (Kleber, Figley & Gersons, 1995).

In accordance with this view that culture is an all-penetrating concept in society, and specifically that culture is bound to affect the manner in which individuals' process and internalise traumatic events, Castillo (1997) describes several functions of cultural meaning systems that are most valuable to utilise when attempting to make sense of unfamiliar cultural meaning whilst dealing with the trauma client. There are four functions of cultural meaning systems described by Castillo (1997) namely; culture as the sum total of knowledge passed on from generation to generation within any given society, and including several aspects such as language, art, religion, social and political structures, economic and legal systems, norms of behaviour, and ideas about illness and healing. He adds that this body of knowledge is always organized in a systemic fashion so that it is easily passed on and internally logical. These systems are referred to as cultural meaning systems and because these meaning systems vary among societies, universal categories of experience may be valid in some instances, but not all.

These cultural meaning systems have four major functions; representational function which provides the means for individuals within a cultural group to represent the world symbolically to themselves and others, constructive function which help people to construct things that would not exist without the meaning system that created them, directive function which represent those entities which are accepted as part of cultural meaning system on the kind of behaviours that are acceptable and not acceptable. The last function is known as evocative function, as cultural meaning systems create cultural entities, these in turn direct the behaviour of individuals which ultimately evoke certain emotions. The discussion above outline the many aspects of what culture includes and how cultural meaning undoubtedly penetrates every aspect of human experience and interaction, including how people are likely to interpret or internalise traumatic experiences and then react to these.



Horowitz (1999) asserts that within families, for example, traumatic reactions increase with inconstancy, lack of control, self centeredness and exploitation of the weak by the strong. Cultural attitudes dictate how people ought or should respond to stress. In some cultures, responding to stress with physical illness is a “good response” and mental illness a “bad” or stigmatised response. In others, the reverse may be true. Stigmatisation will worsen any condition because it undermines crucial supports of self esteem, personal identity and coping efforts (Wilson, Friedman, & Lindy, 2001).

Norms are imparted through socialisation which is a process that gives individuals the knowledge, motivation and skills to participate in their community. These norms regulate attitudes and behaviours and social sanctions can result from deviation from these norms (Amaro, 1995). In terms of trauma culturally determined values can

influence perceptions and attitudes on how a person should express themselves. This is particularly so where the issue of sex roles and gender-related roles is concerned.

Spence, Deaux & Helmreich (1985) argue that even though societal endorsement of gender equality is common in the developed world, there is still resistance to the breakdown of sex roles. Individuals are pressured to conform and function and behave according to their ascribed roles. In many cases, social structures act to maintain the inequality of social relationships between men and women. Clearly culture seems to have a profound impact on people's day to day lives. It is therefore, important that a discussion to follow to explore how men and women react to trauma taking into account the above.

3.4 GENDER DIFFERENCES REGARDING REACTION TO TRAUMA AND TRAUMA SYMPTOMS



Recent epidemiologic surveys in the general population have demonstrated that post traumatic stress disorder (PTSD) is nearly twice as prevalent among women as men (Zlotnick, Zimmerman, Wolfsdorf & Mattia, 2001). Furthermore, women exposed to trauma are more than twice as likely as men to develop PTSD, even when history of multiple traumatic events or sex differences in the type of trauma is taken into account. Research on gender and stress has evolved largely from attempts to account for differences between women and men in psychological distress. With consistency that is quite extraordinary in social and behavioural research, women have been shown to be more likely than men to manifest certain psychological disorders

particularly depression and anxiety (Anashensel & Clark, 1981; Belle, 1980; Dulberg & Joubert, 1999, Suominen, Helenius, Blomberg, Uutela & Kostenvuo, 2000).

Since stress has a prominent place in the conceptual frameworks of research into psychological distress, it is not surprising that it should emerge as a central explanatory construct in theories seeking to account for sex differences. Fullerton, Ursano, Epstein & Crowley (2001) conducted a study whereby they examined whether women have higher rates of posttraumatic stress disorder than men. The study was made of a sample of 122 participants, ages 18 to 65 who were involved in motor vehicle accident. Participants were assessed using structured clinical interview for DSM III-R and the peritraumatic dissociative experiences questionnaire rater version one month after the accident. Findings indicate that women did not differ from men in meeting the overall re-experiencing criterion for a diagnosis of PTSD (criterion B) but women were at greater risk for the specific re-experiencing symptoms of intense feelings of distress in situations similar to the motor vehicle accident. Women were more likely than men to meet the overall avoidance and numbing criterion C and arousal criterion D symptoms (Fullerton et al, 2001).

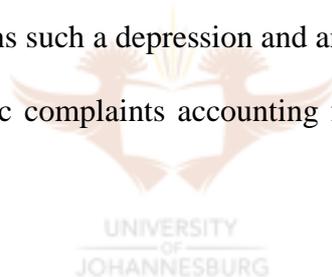
Several studies have suggested risk factors for the development of PTSD that might explain the different rates of PTSD in men and women. People with a history of major depression are at greater risk for PTSD after all types of trauma. Few empirical studies have specifically examined the risk factors as possible explanations for the different rate of post-traumatic symptoms and PTSD in men and women. In a larger study of health maintenance organisation population, pre-existing major depression or

any anxiety disorder seemed to increase vulnerability of lifetime PTSD in women but not in men after control for the type of trauma (Fullerton et al, 2001).

Fullerton et al (2001) argue that two studies found prior depression to be unrelated to the gender differences in PTSD and one study supported prior depression as part of the explanation for this difference. All three studies indicate that prior anxiety disorder cannot explain the higher rate of PTSD in women. However, women and men in the study by Fullerton et al (2001) reported the same frequency of peritraumatic dissociative symptoms. It is therefore important to note that peritraumatic dissociative symptoms appeared to carry a different risk for PTSD in women and men increasing the risk of PTSD significantly more in women. This finding may indicate that there are fundamental neurological differences in peritraumatic dissociation in women and men.

In relation to trauma caused by chronic and terminal illness especially HIV/AIDS Nilsson Schonnesson & Ross (1999) postulate that people with HIV respond to HIV-related stressors in a broad range of modes partly as a result of their adaptation processes. The mode spectrum varies from psychiatric disorders to transient mood symptoms. According to Nilsson Schonnesson (2001) the vast majority of empirical research is cross sectional and has focused on whether there are differences in distress between people with HIV and those uninfected. 'People' in research usually refer to men and in particular gay men. Although HIV-infection rates among women continue to accelerate in the world and the lives of many women with HIV infection are dominated by complicated realities, there is an embarrassing void of studies regarding the gender-specific psychological, sexual and social of women with HIV infection.

It is estimated that between five to eight percent of AIDS line references on depression, mood disorders and quality of life, respectively include women. Depression in particular has over the years received major attention. Clinical data show depressive disorders have increased over time, whereas adjustment disorders have decreased (Catalan, Green & Thorley, 2001). Data also suggest that women with HIV have substantially higher rates of depression than their male counterparts (Ikovics, Hamburger & Vlahov, 2001). It has also been suggested that women are more susceptible to health problems because of menstruation and pregnancy as well as differences in chemical and hormonal composition expose women to greater health demands (Steward, 2001). Nolenhoeskema & Rusting (1999) assert that men and women cope differently with stress and that women are more prone to internalise their problems. If negative emotions such a depression and anxiety are internalised, it could lead to greater psychosomatic complaints accounting for higher score in depression and anxiety.



Most researchers agree that psychological and social factors have important influence on mental health. However, there is still little consensus about the mechanisms linking social factors and health outcome or the extent to which social factors explain observed differences in mental health (Aspinwall & Straudinger, 2003; Connors, 1990; Eagly, 1987). In order to have more advanced knowledge in this area, it is incumbent upon researchers to move beyond descriptive studies to investigations that look in detail at the biological, psychological and social processes that influence health in general. It is also important to keep in mind the inherent limitations in the ability of researchers to identify generalisation principles. In order to understand the

meaning of sex differences in trauma related reactions, the issue of culture in which behaviours occur need to be taken into account (Bach, 2000).

Among many functions as alluded to in the above discussion, culture also act as a context for the psychological development of individuals. Moreover it provides a context within which behaviour is expressed according to social norms and provides a basis for interpretation of what is socially approved. An awareness of how gender differences are manifested may be beneficial in any context requiring interaction between men and women, such a educational institutions, workplace and relationship to mention but few (Lu, 2000).

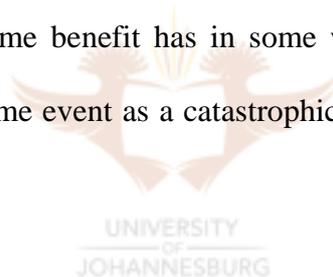
All people are equal but not the same, therefore greater knowledge concerning gender differences may precipitate greater opportunities for further promotion of optimal psychological well being, both in men and women. Greater knowledge may also help to identify and redress historical imbalances between resources, opportunities and protective factors for men and women.

Recent literature asserts that people have unequal success when dealing with the same hardships. Then the question arises as to what the difference is in those individuals who may experience a traumatic event or hardship and not be traumatised? The following section focuses on the role that resiliency play when dealing with trauma, especially that of being diagnosed with such a fatal illness as HIV/AIDS.

3.5 ADJUSTMENT AND RESILIENCY

Post-traumatic stress reactions have multiple causes. By definition, the experience of a traumatic event is the necessary. But not all survivors of traumatic events go on to develop severe or chronic distress. So although the experience of traumatic event may be a necessary cause, it is not a sufficient cause and various psychosocial factors must either mediate or moderate the effects of traumatic events (Joseph, Williams & Yule, 1997). It is not just what happens to people that is important, but also what it means to those people in relation to their sense of who they are, the world they live in and what their expectations are for the future.

Therefore exposure to traumatic events can challenge the whole meaning of a person's life and his or her sense of purpose. One person might construe an event as a lucky escape from which some benefit has in some way derived, whereas another person might construe the same event as a catastrophic misfortune which proves that life is meaningless.



3.5.1 Conceptualised models of adjustment

Many theorists of adjustment to illness derive from more general conceptual frameworks regarding adjustment to stressful or traumatic experiences. One of the most prominent among these is Lazarus and colleagues (e.g., Lazarus & Folkman, 1984; 1985; Sabboni & Hurny, 1990). According to Lazarus, central determinants of adaptive outcomes include personal resources, attributes of the situation, cognitive appraisals and coping strategies. Although Lazarus and Folkman (1984) discussed pre-existing resources and situational attributes, they were more interested in

processes initiated by the individual that unfold over the course of the stressful encounter.

These include individual's cognitive appraisal of the potential for harm (i.e., threat appraisal) and benefit (i.e., challenge appraisals) arising from the encounter (i.e., primary appraisal), as well as appraisals of their ability to control or manage the situation's demands (secondary appraisal). These processes of appraisal catalyse the initiation of coping strategies which are cognitive and behavioural efforts to manage specific external and or internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman, 1984).

According to Lazarus and Folkman (1984) these cognitive appraisals and coping strategies engaged in response to stressor substantially determine adaptive outcomes in emotional, social, and somatic realms. Similarly, Moos and colleagues (e.g. Moos & Schaefer, 1993) included in their conceptual model of stress and coping the influences of the environmental system (e.g. life stressors, social resources), the personal system (e.g. demographic and personal attributes), life crises and transitions (i.e. event related factors), and cognitive appraisal and coping processes on each other and on health and well being.

Specific theorists on adjustment to chronic illness expand on such general conceptual frames. An example is the model of Maes, Leventhal and de Ridder (1996). They expanded on Lazarus and Folkman (1984) theory by emphasizing the potentially important roles of contextual factors (e.g. other life events, demographic attributes, cultural and social environment), characteristics of the specific disease situation (e.g.

asthma in general versus a specific asthmatic attack), and associated disease representations (e.g. appraisals of the identity, controllability, duration, causes and consequences of the disease and symptoms).

As with other theorists Maes et al (1996) also focused on the influence of individuals' life goals on disease representations and coping processes. The more individuals' central goals in life are threatened by the disease, the more stressful the situation, and more appraisal, coping processes, and internal and external resources are challenged. Perceived goal blockage is likely to engender distress and an attempt to cope.

Coping processes can be understood as lower order goals (e.g. express emotions about having cancer) that serve as a path to achieving higher order goals (e.g. maintain emotional balance, live a fulfilling life) (Lazarus, 1991). Also relevant with regard to the importance of goals in coping and adaptation is the regulation theory of Carver and Scheier (1998) which they have applied to coping with illness (Scheier & Bridges, 1995). In their view "illness represents one general and significant class of events that can interfere with the pursuit of life's activities and goals, both those that are health related and those that are not illness can interfere to a lesser or greater extent with the general set of plans and activities that give a person's life its form and meaning" (Scheier & Bridges, 1995, p.130).

To the extent that an individual expects to continue successful goal pursuit in the face of having a chronic disease, then initiation of approach oriented coping strategies are likely. However, if a person expects unremitting goal blockage, then disengagement may ensue.

Two broad conclusions extend from the descriptive literature on adjustment to chronic illness. First, most individuals appear to adjust well to chronic illness, often resulting in psychological adjustment indicators comparable to or slightly below general population norms and more positive than individuals who carry psychological diagnoses (Stanton, Collins & Sworowski, 2001). Given that chronic illness presents numerous potential stressors, how can we account for this apparent positive psychological adaptation? Several explanations are possible. Perhaps most individuals are able to master sufficient internal and external resources in the face of chronic illness to maintain high quality of life.

Another compatible possibility is that chronic diseases carry the potential for positive as well as negative consequences and that people's ability to extract positive meanings from their disease experience balance any negative consequences. For example, Folkman, Moskowitz, Ozer & Park (1997), in a study of HIV-positive and HIV-negative care giving partners of men with AIDS, found that although study participants reported high levels of depressive symptoms, they also display positive morale and positive states of mind comparable to general population norms, and they reported experiencing positive meaningful events.

A third possibility is that, as mentioned previously, individuals shift their comparison standards as they adapt to disease, so that they evaluate their own adjustment *visa versa* their status as a person, and they compare themselves to others with arthritis rather than as a healthy person. Thus owing to pervasive human tendencies toward positive self evaluation and toward comparing themselves favourably to others who under similar threats (Stanton, Danoff-Burg, Cameron, Snider & Kirk, 1999).

A second conclusion is that considerable variability is apparent in psychological adjustment, both across studies and across individuals within single studies. Moreover, individuals variability in reaction to chronic illness certainly is to be expected, given that any particular disease represents multiple stressors (e.g. pain, threat to life, ambiguity regarding the future, appearance and functional changes, interpersonal challenges, financial strain), each of which may or may not be pertinent to a specific individual. Such stressors will carry differential relevance, depending on such factors as the individual's goal structure, psychological and contextual resources and specific coping strategies. For example, individuals whose experience with serious disease saps already scarce environmental and personal resources may be at substantial risk for pronounced life disruption and distress (Stanton et al, 2001).

There is accumulating evidence that the manner in which individuals cope with difficult or stressful events can influence their psychological well being (Endler & Parker, 1990; Lazarus & Folkman, 1984; McCrae & Costa, 1986). While there is a growing trend to view coping as a process that changes over time and in response to changing situational demands (Lazarus & Folkman, 1984) there is also support for the notion that individuals have particular coping styles that transcends the influence of situational context or time (Carver, Scheier & Weintraub, 1989).

One individual variable that has been frequently studied in association with coping is gender. Traditional gender role stereotypes suggest that men are socialised to emphasise instrumental behaviour and to suppress emotions and are thus more likely to use problem-focused coping. In contrast, women are socialised to express emotion and seek social support and may therefore rely more on emotion-focused strategies

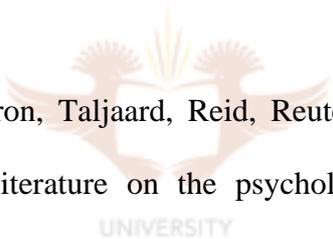
(Folkman & Lazarus, 1980; Ptacek, Smith & Dodge, 1994; Placek, Smith & Zanas, 1992).

3.5.2 Gender differences in adjustment to trauma

Analyses of gender differences in coping have produced mixed results. Some studies have found results consistent with socialisation hypothesis; men tend to use more problem-focused coping than women and women tend to use more emotion-focused coping (Billing & Moos, 1981; Folkman & Lazarus, 1980; Ptacek et al, 1992; Ptacek et al, 1994; Stone & Neale, 1984). In contrast, Parkes (1990) found that men used more suppression which refers to an emotion-focused measure characterised by restraint, withdrawal and ignoring the problem and equal amounts of direct coping referring to an active, problem-focused strategy as women were when dealing with adversities. However, other studies still found no differences in the way in which men and women cope (Hamilton & Fagot, 1988; Porter & Stone, 1995).

One possible explanation for gender differences in coping concerns gender differences in the content of problems experienced or reported on coping assessments. There is evidence that problem content is related to coping and gender is related to problem content (Porter & Stone, 1995). For example, work-related problems which are more frequently reported by men are associated with higher levels of problem-focused coping in both men and women. However, health-related problems, which are more often reported by women, are associated with increased emotion-focused coping (Folkman & Lazarus, 1980).

This argument suggests that findings of gender differences in coping may be confounded with gender differences in the content of problems experienced. This argument is in line with one of the recent findings on coping with HIV/AIDS. McDaniel, Musselman & Porter (1995) found that the majority of HIV-positive people in the United States of America appears to be psychologically resilient. The rates of current major depression are in the five to nine percent range comparable to those presented by people with cancer (McDaniel et al, 1995; Rabkin, Ferrando & Jacobsberg, 1995). Furthermore, there are indications that those currently suffering from depression have had depressive episodes that antedate HIV infection (Atkinson & Grant, 1994). Recent data also indicate that women with HIV have higher rates of depression than their male counterparts (Ickovics et al, 2000).

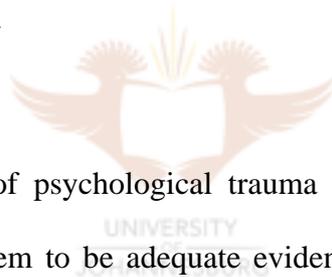


Olley, Gxamza, Seedat, Theron, Taljaard, Reid, Reuter & Stein (2003) argue that although there is growing literature on the psychological responses to and the psychopathology associated with HIV/AIDS, few investigations have focused on the role of gender in shaping these outcomes. They then conducted a study in South Africa whereby they seek to compare psychiatric morbidity, coping responses and disability in male and women outpatients recently diagnosed with HIV/AIDS. A sample of 44 male and 105 female with HIV infection was assessed using the International Neuropsychiatric Interview, Carver Brief Cope and Sheehan Disability scale. Findings indicate that 50% of participants were diagnosed with a psychiatric disorder, most commonly major depression, dysthymic disorder and PTSD. There were no significant gender differences in the prevalence of mood disorders in this sample. Men however, were more likely than women to meet the diagnostic criteria for alcohol abuse or dependence and to engage in certain risky sexual behaviours

(Olley et al, 2003). Women on the other hand were more likely to suffer from PTSD and use coping strategies of planning and religion to deal with the illness. These findings may be a reflection of high levels of stigmatisation and stress faced by HIV/AIDS patients in South Africa.

Therefore, the above findings on HIV/AIDS patients corresponds with those by Simoni and Ng (2000) who found that women in New York used adaptive coping strategies more frequently than avoidant ones. It is also evident that gender differences seem to play a role in determining the coping strategy likely to be chosen by those confronted with a range of problems.

3.6 CHAPTER SUMMARY



In this chapter the history of psychological trauma was briefly explored and the definitions thereof. There seem to be adequate evidence that reactions to traumatic vary immensely and this variation can be attributed to a number of factors. An interactional model of traumatic reaction was explored and the various aspects that characterise it. The important role that culture plays in as far as people's understanding of themselves and the world in which they live was also discussed. Evidence from studies that examined issues relating to adjustment to traumatic phenomenon were also discussed. Lastly, how all the above affect and influence the reaction of men and women in terms their reactions to traumatic events were discussed.

CHAPTER FOUR



METHODOLOGY

4.1 INTRODUCTION

This chapter will explore the methodology of the current study. The first part of the chapter will focus on the research design used in the study, followed by an exploration of the sample and the procedure used to select current study participants. Thereafter, a discussion on the measuring instruments and their psychometric properties will follow. The second part will focus on the hypotheses that the current study seeks to investigate followed by the ethical considerations. Then the chapter will conclude by a brief discussion of the statistical analysis utilised in the current study.

4.1.1 Research design

The proposed research is a comparative *ex post facto* design. In this type of design, the researcher begins with two or more groups of subjects that already differ according to one variable. The term *ex post facto* literally means “after the fact” and refers to what one might call real-life studies that employ some of the same measurement and statistical tools as used in experimental and quasi-experimental studies. The difference is in the lack of direct control over the independent variables such as life experiences which replace researcher-determined treatments that would

have been possible in a more structured situation (Neuman, 1997). In the present study, two groups of subjects were selected, namely females and males. The subjects were taken from various institutions that deal with people who are diagnosed with HIV infection.

In the *ex post facto* design, the behaviour of the two groups is recorded to ascertain if their responses are different in terms of a given behaviour or behaviours. In the present study, the two groups were compared regarding the post traumatic reaction upon receiving news about their HIV positive status. Their reactions were measured using the various measures of posttraumatic reaction and adjustment. The discussion to follow deals with the type of participants used in the study and fully details how and where the participants were obtained.



4.1.2 The sample

The type of sampling method used is referred to as the purposive or judgemental sampling. Purposive sampling is defined as samples that result when the researcher handpicks the elements to be included in the sample on the basis of expert judgement. The individuals selected may be either judged to have certain characteristics, or those which will be able to provide useful information for the purposes for which the study is being conducted (Neuman, 1997). The purposive sampling technique is of assistance in exploratory research in that it allows the researcher to streamline the sample in order to elicit baseline data (Rosenthal & Rosnow, 1991).

Men and women who are diagnosed with HIV infection, above the age of 18, who are single or married were recruited from the various organisations in the Gauteng region. People who participated in this study were taken from organisations operating in the Gauteng region.

The researcher thought it would be beneficial to follow this line of investigation into the issues relevant to particular age groups, thereby allowing for elimination of extraneous variables.

In order to ensure that respondents belonged to the targeted groups and to also investigate other possible factors apart from gender that may influence their responses, a list of biographical questions was attached to the questionnaires. The biographical details included the following, age, gender, marital status, level of education, dependents/children, employment status and year of finding out their status and issues relating to disclosure and access to support.

4.1.3 Procedure

A number of institutions working with people who are diagnosed with HIV infections were contacted by the researcher, both governmental and non governmental. A number of institutions also run support groups and wellness clinics for people who are HIV positive. As a result a large number of participants were attained from support groups. The researcher contacted persons in charge at the various institutions and after permission was granted facilitators of groups met with the researcher. Participants from the following organisations participated in this study:

- AIDS link and CARE support group from Hillbrow
- Grace Bible Church support group from Soweto
- Rophe community centre in Yeoville
- Soweto Hospice in Soweto
- Zimba-Nathi organisation from Thembisa

It emerged from meetings that the researcher had with facilitators of various support groups that other people attending these groups have not yet disclosed to their families, therefore would prefer to deal with someone they know such as a group facilitator. Of the six places contacted one required that the researcher assign the task of distributing questionnaires to personnel working at the place to ensure that identities of those people who have not yet disclosed remain confidential. The researcher then met with support group members at those organisations where support group members agreed to participate and to meet with the researcher. Selection of participants was based on availability. The researcher explained to members of the support group what the purpose of the study was and reassured members of the confidentiality of the process. The researcher then encouraged participants to try and be as honest in answering the questions as they can be. Counselling services were made available for those who could find the process of the answering questionnaire perturbing.

A senior nursing Sister from Soweto Hospice known to the researcher was contacted and agreed to facilitate the process on the researcher's behalf since the institution requested that identities of those who have not yet disclosed to remain confidential. The selection was based on availability and anonymity of all participants was assured.

Before participants could commence with the filling in of the questionnaire, the Sister in charge explained the purpose of the study and described the testing material in order to ensure that respondents fully understood what was required. All questionnaires were treated in confidence and no names were requested. No fixed time limit was stipulated for the completion of the questionnaire.

After all participants had completed filling the questionnaire, they were then thanked by the person in charge at various institutions and the researcher also attached a note on the questionnaire in which he thanked each participant for their contribution in the study. The respondents' answer sheets were then all scored manually and checked by a colleague for accuracy, recorded on a schedule and then given to the Statistics Consultants at Statkon (University of Johannesburg) for statistical analysis. A discussion of the measuring instruments chosen for the current study will now follow.



4.2 MEASURING INSTRUMENTS

In an attempt to measure the posttraumatic stress reaction of men and women after discovering their HIV positive-status, two measuring instruments which were utilised namely; the Impact of Event Scale-Revised (Weiss & Marmar, 1997) and the Mental Adjustment Scale to Cancer Scale (Modified) (Greer, Young & Watson, 1998).

Each questionnaire will be described in terms of content, administration, scoring and psychometric properties.

4.2.1 The Impact of Event Scale (IES-R)

The IES-R was developed by Daniel S. Weiss and Charles R. Marmar in 1997 to parallel the DSM-IV criteria for PTSD. The original IES was developed prior to the adoption of Posttraumatic Stress Disorder as a legitimate diagnosis in the DSM-III published in 1980, and only measure two of the four criteria set out for PTSD in the DSM-IV: intrusion and avoidance (Weiss & Marmar, 1997). IES-R was intended to also measure hyperarousal cluster of symptoms, the 4th criterion for PTSD.

The IES-Revised is similar to IES in that it is a self-report measure designed to assess current subjective distress for any specific life event. The IES-R has 22 items, seven items having being added to the original 15-item IES (Weiss & Marmar, 1997). The seven items comprise of six that measure hyperarousal symptoms such as: anger and irritability, heightened startle response, difficulty concentrating, hypervigilance; and one new intrusion item that measures the dissociative-like re-experiencing when experiencing true flash-back. The hyperarousal subscale and the new intrusion item along with the existing intrusion and avoidance subscales parallel the DSM-IV criteria for PTSD.

The seven items are randomly interspersed with the existing seven intrusion and eight avoidance items. The only modification to the IES items was the bifurcation of the item "I had trouble falling asleep or staying asleep" into "I had trouble falling asleep" (assigned to the hyperarousal subscale), and "I had trouble staying asleep" (retained in the intrusion subscale).

Respondents are asked to rate each item in the IES-R on a scale of 0 (not at all), 1 (a little bit), 2 (moderately), 3 (quite a bit) and 4 (extremely) according to the past seven days.

4.2.1.1 Reliability

In their study of four different population samples, Weiss & Marmar (1997) reported that the internal consistency of the three subscales was found to be very high, with intrusion alphas ranging from .87 to .92, avoidance alphas ranging from .84 to .86, and hyperarousal alphas ranging from .79 to .90 (Briere, 1997).

Test-retest data are available for two of the samples in the Weiss & Marmar (1997) study. Data from sample one (n = 429) yielded the following test-retest correlation coefficients for the subscales: intrusion = .57, avoidance = .51 and hyperarousal = .59. From sample 2 (n = 197) the correlation coefficients were considerably higher: intrusion = .94, avoidance = .89 and hyperarousal = .92 and it is believed that the shorter interval between assessments and the greater recency of the traumatic event for sample two contributed to the higher coefficients of stability.

4.2.1.2 Validity

Validity refers to a degree to which a scale succeeds in measuring what it intends to measure. In terms of validity Weiss & Marmar (1997) noted that the hyperarousal subscale has good predictive validity with regard to trauma (Briere, 1997). The intrusion and avoidance subscales, which are original IES components, have been shown to detect change in respondents' clinical status over time and detect relevant differences in the response to traumatic events of varying severity (Weiss & Marmar, 1997, Horowitz, Wilner & Alvarez, 1979).

Content validity which refers a degree to which test scores represent the domain of interest is not available for the hyperarousal subscale. The intrusion and avoidance subscales which are originally IES items had high endorsements of up to 85% (Horowitz, et al 1979). In terms of construct validity Weiss & Marmar (1997) utilised the item-to-subscale correlation with that item removed from the subscale generated by the standard alpha coefficient analyses.

These were then compared to the cross-subscale Pearson correlations. The results showed that only one item ("I had trouble falling asleep") showed a stronger relationship between it and a different subscale. The corrected correlation of this item with its assigned hyperarousal subscale was .71, and its correlation with the intrusion subscale was .79, 19 items showed a correlation with their assigned subscale that was higher than with the other subscales; and two items ("I had trouble staying asleep" and " I avoided letting myself get upset when I thought about it or was reminded of it") showed a correlation that was equal.

The explanations given by Weiss & Marmar (1997) for these results are that the two sleep items are very highly correlated, driving a relationship between them in terms of intrusion and hyperarousal, and as to the equal relationship of the avoidance item with the avoidance and intrusion subscales, this may have occurred because the presentation of the thought or the reminder invokes intrusion, and the not dealing with it invokes avoidance.

4.2.1.3 Scoring method

In this section a discussion on the scoring method for the various subscales and examples thereof will be discussed. (See appendix for full scale).

The first subscale is the Avoidance subscale which consists of the following mean of items 5, 7, 8, 11, 12, 13, 17 and 22. Examples thereof are as follows: Item 5 (*I thought about my HIV positive status when I didn't even want to*) and Item 11 (*I avoided dealing with my feelings*).

The second subscale is the Intrusions subscale which comprises of the following mean of items 1, 2, 3, 6, 9, 14, 16 and 20. Examples thereof are as follows: Item 1 (*I had trouble sleeping at night*) and Item 9 (*I experienced shock*).

The third subscale is the Hyperarousal subscale which comprises of the following mean items: 4, 10, 15, 18, 19 and 21. Examples thereof are as follows: Item 4 (*I allowed myself to get angry when I thought about my HIV-positive status*) and Item 18 (*Anything that reminded me of my HIV positive status caused me to have physical reactions, such as sweating, trouble breathing, nausea or pounding heart*).

Therefore the Impact of Event Scale-Revised (IES-R) score consists of the sum of the three clinical scales indicated above. It should be noted however that for valid comparisons with scores from IES-R, only the sum of the Avoidance and Intrusion

subscales should be used. Kimerling et al (2002) allege that the IES-R has been validated with a variety of populations, including combat veterans, male and female survivors, female sexual assault survivors, natural disaster victims and accident victims. Moreover, the scale allows for assessing all three PTSD symptom clusters. Therefore it may be extremely useful as a screener or to measure symptom changes over time, however it is not recommended as a stand-alone instrument for making diagnostic decisions.

The discussion to follow reports on Factor analysis of the above instrument as applied to the current study.



4.2.1.4 Factor Analysis for IES-R

Factorial analysis of variance is widely used in the social sciences. It is commonly recognised that one of the advantages of a factorial design is that it permits the researcher to analyse interaction effects between independent variables relative to the dependent variable (Jaccard, 1998).

It is also known as a technique used to reduce the number of variables and to detect underlying structures within variables. In other words, it groups questions together that relate to a similar topic, as these questions are usually highly correlated with one another. Each of these groupings are then referred to as “Factors”.

The current study's first order factor analysis was done on the IES-R and revealed five Factors of which three showed adequate reliability. Table 4.1 provides a summary of the Factors found on the Impact of Event Scale-Revised (IES-R).

Table 4.1 First order analysis for IES-R

Factor	Rotated Factors	Results	Cronbach's Alpha
1	Item 12 Item 15 Item 16 Item 10 Item 7 Item 8	0.643455429 0.633862985 0.605290242 0.577979847 0.54806294 0.441233361	0.826
2	Item 19 Item 2 Item 5 Item 17 Item 3 Item 6 Item 18	0.705123431 0.699418758 0.666563147 0.612925735 0.500009589 0.437121029 0.373690583	0.857
3	Item 14 Item 1 Item 13 Item 4	0.77189908 0.628684213 0.571945588 0.414765039	0.757
4	Item 20 Item 21	0.722619221 0.718965131	0.760
5	Item 11 Item 9	0.765629328 0.553584705	0.644

As can be seen from Table 4.1, the first three Factors consist of more than three items each and is also shown to have good reliability (Cronbach Alpha = 0.826, 0.857, 0.757). The fourth Factor although displaying adequate reliability was found to consist of only two items and the fifth was found not to be reliable (Cronbach Alpha = 0.644).

A second order factor analysis for the current study found only one Factor with a Cronbach Alpha of 0.924 which suggests an excellent reliability for all items of the IES-R taken together. It was therefore decided to use only the total score of the IES-R

in statistical analysis as no empirical support could be found for the three subscales (avoidance, intrusions and hyper-arousal) as postulated by Weisman & Marmar (1997).

4.2.2 The Mental Adjustment to HIV Scale (Modified version of Mental Adjustment to Cancer Scale)

The Mental Adjustment to Cancer Scale (MACS) was developed by Greer, Young & Watson (1998) as a means of assessing the general adaptation of individuals with life-threatening illness, provides a comparison with data from patients with cancer, enables assessment of positive coping style (e.g., fighting spirit) and investigates the application of patterns of psychological adaptation to life threatening illness across different disease groups.

The 40-item Mental Adjustment to Cancer Scale (Greer, Young & Watson, 1998) was modified by Kelly, Raphael, Burrows, Kernutt, Burnett, Perdices & Dunne (2000) for use in those diagnosed with HIV infection to make the scale applicable and suitable for use with HIV-positive population (Mental Adjustment to HIV Scale).

Instructions for the original instrument were modified to address “reactions to having HIV infection or AIDS” (rather than cancer) and individual items modified for HIV infection by replacing “cancer” with HIV infection or AIDS, similar to the

modifications reported by Ross, Hunter & Condon (1994). The scale was modified in order to be applicable to those who are diagnosed with HIV/AIDS and to further identify items that are unique to HIV/AIDS.

The original version of this questionnaire is a self-report instrument examining a range of cognitive and emotional responses to cancer which provides scores on the following subscales: Fighting Spirit (16 items), Helplessness/Hopelessness (six items), Fatalism (eight items) Anxious Preoccupation (nine items), and Avoidance (one item). According to Greer et al (1987) and Watson et al (1998) the MACS has established validity and reliability in a range of cancer populations and has concurrent validity with clinician ratings of coping. Each item presents a statement concerning a response to the disease (e.g. "I feel that nothing I can do will make a difference"), and the respondent is asked to indicate "How far it applies to you at present" on a four-point scale from "Definitely does not apply to me" to "Definitely does apply to me".



4.2.2.1 Reliability

In the Study by Ross et al (1994) five Factors were detected on the MAHIVS of which only two had internal consistency scores of greater than .65. The first Factor, which contributed over 21% of variance, represented Helplessness/Hopelessness, similar to the same Factor detected by Watson et al (1998) in cancer population. Furthermore in the study by Kelly et al (2000) wherein 167 HIV positive homosexual men were assessed using the MACS, the internal reliability of the four Factors were assessed using Cronbach's Alpha coefficient. Factors one and two demonstrated a high level of internal reliability (.84 and .80 respectively).

Moreover the pattern observed with the group of 167 HIV-positive men in a study by Kelly et al (2000) is similar to that found by Schwartz, Daltroy, Brandt, Friedman & Stolbach (1992) in a study of 239 cancer patients as both studies detect a factor of hopelessness and varying forms of positive attitudinal reactions.

The alpha coefficient levels are influenced by number of items in each factor and limited internal reliability of factors 3 and 4 may reflect the small number of items in each (findings for these two scales should be interpreted cautiously).

Data from sample (n = 163) yielded the following test-retest correlation coefficients for the subscales: Hopelessness=.48, Fighting spirit=.40, Personal control=.26.

4.2.2.2 Validity



The validity of the MAHIVS was supported by the significant correlation between factors (Hopelessness and Fighting Spirit) with significant correlations detected between psychological symptoms and other measures of psychological adjustment and personality. Fighting Spirit emerged as a potential indicator of psychological resilience, whereas Hopelessness was significantly associated with psychological symptoms of current major depression (but not past depression).

In summary, the two instruments used in the current study seem to be quite reliable and valid, given the focus on HIV/AIDS and the relative ease with which the questionnaires can be filled, it seems as if they are suitable for use in the current study. However, it is important to note that the MAHIVS has only been tested using

gay and bisexual males, therefore there is no information regarding its usage among women .A discussion of the factor structure follows.

4.2.2.3 Factor structure (MAHIVS)

The current study’s first order analysis revealed six Factors. Table 4.2 provides a summary of the six Factors which were found.

Table 4.2 First order analysis for MAHIVS

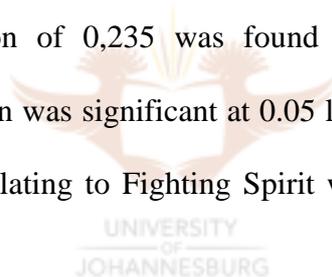
Factor	Rotated Factors	Results	Cronbach’s Alpha
1.	Item 4 Item5 Item 13 Item 12 Item 15 Item 18	0.720738 0.698511 0.691446 0.546657 0.366432 0.304317	0.742
2.	Item 11 Item 14 Item 16 Item 20 Item 3	0.796426 0.625932 0.541635 0.53688 0.450827	0.778
3.	Item 7 Item 2 Item 1 Reversed Item 19	0.720098 0.539857 0.38146 0.307509	0.572
4.	Item 9 Item 10	0.791533 0.526505	0.815
5.	Item 17		N/a
6.	Item 8		N/a

As can be seen from Table 4.2, the first Two factors consist of more than three items each and are also shown to have significant reliability (Cronbach Alpha = 0.742 and 0.778). The third one consists of four items but does not display adequate reliability. The fourth one, though it consists of only two item it showed to have good reliability.

A second order factor analysis showed two factors. The first second order factor consists of the following items on the MAHIVS (4, 5, 13, 12, 15, 18, 9, 10, 17, 8).* (see appendix for complete scale). The reliability of this factor was shown to be 0,843 which is indicative of good reliability. Inspection of the items revealed that they all deal with Fighting Spirit.

The second order factor consists of the following items on the MAHIVS (11, 14, 16, 20, 3, 7, 2, 1reversed, 19).* (see appendix for complete scale). The reliability of this factor was shown to be 0.785 which indicates adequate reliability. Inspection of these items revealed that they all deal with Hopelessness.

Lastly, a Pearson correlation of 0,235 was found between Fighting Spirit and Hopelessness. This correlation was significant at 0.05 level. This means that a person who scored high on items relating to Fighting Spirit would be more likely to score low on Hopelessness.



4.4. PROBLEM STATEMENT

Finding out one is HIV infected is a significant discovery. In receiving an HIV-positive diagnosis, individuals are exposed to news of prodigious personal consequence (Phillip & Coates, 1995). People's perceptions of such pivotal health information affect the actions they are able to take. Society expects people newly diagnosed with HIV to learn about the disease, change risky sexual and drug use behaviours, improve health habits and participate in treatment. But if the distress of having HIV is too great, how can they do these things? (Steven, 1996).

Initial subjective experience of HIV seropositivity can have ramifications for future outcomes of longevity, quality of life and prevention of transmission (Alonzo & Reynolds, 1995). According to the Centre for Disease Control and Prevention (2000) women are the fastest-growing group being infected in the World, especially in Africa. Initially the majority of people with AIDS used to be men however, current studies on HIV/AIDS reveal that women are progressing from seropositivity to AIDS almost four times as fast as men (Update: AIDS, 1995; Farzaden et al, 1998). And yet researches reveal very little about women's reactions to an HIV-positive diagnosis and it is also unknown whether men and women's reactions to an HIV-positive diagnosis differ.

Therefore, the current study is undertaken to determine whether men and women differ in terms of their reaction to an HIV-positive diagnosis. Furthermore, studies have shown two significant reactions to an HIV-positive diagnosis, namely trauma and shock as well as differing degrees of adjustment (Green, 1990; Steven et al, 1997). The goal of the current study is therefore to compare post traumatic symptoms in men and women newly diagnosed with HIV-positive diagnosis.

4.4.1 Hypotheses

The main hypotheses to be examined in this study are as follows:

- Null hypothesis 1: There will be no significant differences between men and women newly diagnosed with HIV/AIDS in terms of their overall post traumatic symptoms in reaction to news about their HIV positive-status.

The above aspects will be operationalised by measurement on the Impact of Event Scale Revised (IES-R).

- Null hypothesis 2: There will be no significant differences between men and women diagnosed with HIV/AIDS in terms of Fighting Spirit.
- Null hypothesis 3: There will be no significant differences between men and women diagnosed with HIV/AIDS in terms of Hopelessness.

The above aspects are operationalised by measurement on the Mental Adjustment to HIV Scale (MAHIVS) and its subscales Fighting Spirit and Hopelessness.

- Null hypothesis 4: There will be no significant correlations between Impact of Event and Fighting Spirit.
- Null hypothesis 5: There will be no significant correlation between Impact of Event and Hopelessness.

These hypotheses will be tested by computing correlations between the subscales of the MAHIVS and the IES-R scale.

4.4.2 Ethical considerations

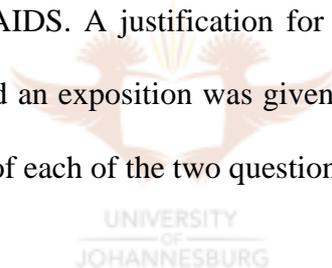
The issue of confidentiality was assured. Confidentiality is defined by Berg (1995) as an active attempt to remove from the research records any elements that might indicate the subject's identities. The issue of informed consent* was also sought, which is defined as the knowing consent of individuals to participate as an exercise of their choice, free from any element of fraud, deceit or similar unfair inducement or manipulation (Berg, 1995). *(See appendix for consent form).

4.5 STATISTICAL ANALYSIS

The two groups were compared with Student's T-test to determine if their vector of average differs significantly with regard to the subscales of the two scales taken together. The analysis of variance indicates in which variables any differences may or may not exist between the two groups.

4.6 CHAPTER SUMMARY

In this chapter the research methodology has been discussed describing the selection process aimed at obtaining a sample from various institutions that work with people who are infected with HIV/AIDS. A justification for the use of the two measuring instruments was provided and an exposition was given of the content, administration and psychometric properties of each of the two questionnaires used.



The two questionnaires consisted of the Impact of Event Scale –Revised (IES-R) and a modified version of the Mental Adjustment to Cancer Scale (The Mental Adjustment to HIV Scale-MAHIVS). Lastly, the current study hypotheses, ethical considerations and the statistical analysis utilised were discussed. The following chapter will focus on the results of the current study.

CHAPTER FIVE



RESULTS

5.1 INTRODUCTION

The goal of this chapter is to outline the results that were found in the respective statistical analysis. Data from questionnaires were entered by the Statistical Consultancy Services (Statkon) into statistical spread-sheet. The spread-sheet was checked for accuracy and factorial analyses were performed as subscale scores as stipulated by authors of respective instruments were not calculated. Statkon utilised the Statistical Package for Social Science (SPSS) computer program for analysis.



Firstly, the discussion to follow will focus on reporting the frequencies with regard to the biographical data. Secondly, the differences between men and women with regard to various subscales will be reported. Thirdly, the correlation between the subscales of the various instruments will also be reported.

5.2 FREQUENCY DISTRIBUTION OF BIOGRAPHICAL VARIABLES

In order for the researcher to gain insight into the sample used, participants were requested to report on various biographical variables. To follow are those variables:

5.2.1 Age

The frequency distribution of age for the current study sample is presented in Table 5.1 below:

Table 5.1 Frequency distribution of Age

Age Group	Frequency	Percentage of people who Responded to this question (n = 97)
11-18	4	4.1%
19-25	18	18.6%
26-35	39	40.2%
36-40	18	18.6%
40 or older	18	18.6%
People who did not respond To this item	3	3.0%

As can be seen from Table 5.1, 4.1% of the people who responded to this item (N = 97) were in the age group 11 to 18, 18.6% were in the age groups 36 to 40 and 40 or older. A significant majority of 40.2% participants were in the age group 26 to 35. Three people of the total sample (N = 97) did not respond to this item.

5.2.2 Gender

The frequency distribution of gender for the current study sample is presented in Table 5.2 below:

Table 5.2 Frequency distribution of Gender

Gender	Frequency	Percentage of people who Responded to this question (n = 100)
Male	38	38.0%
Female	62	62.0%

As can be seen from Table 5.2, 38% of people who participated in this study (N = 100) were males and 62% were females. Women appears to be the fastest growing population of people diagnosed with HIV/AIDS in Southern Africa and the current study appears to support that finding.



5.2.3 Marital status

The frequency distribution of marital status for the current study sample is presented in Table 5.3 below:

Table 5.3 Frequency distribution of Marital Status

Marital Status	Frequency	Percentage of people who Responded to this question (n = 99)
Married or Cohabiting	21	21.2%
Divorced /Widowed or Separated	13	13.1%
Single	65	65.7%
People who did not respond to this item	1	1.0%

As can be seen from Table 5.3, 21.2% of people who responded to this item (N = 99) indicated that they were married or cohabiting, 13.1% were divorced/widowed or separated. The majority of people indicated that they were single (65.7%). Of the total sample (N = 100) one person did not respond to this item.

5.2.4 Education Level

The frequency distribution of Level of Education for the current study sample is presented in Table 5.4 below:

Table 5.4 Frequency distribution of Level of Education

Level of Education	Frequency	Percentage of people who Responded to this question (n = 99)
Standard 8 or lower	32	32.7%
Standard 9	17	17.3%
Matric/Grade 12	34	34.7%
College/Technikon education/ University degree(s)	15	15.3%
People who did not respond to this item	2	2.0%

As can be seen from Table 5.4, 32.7% of people who responded to this item (N = 98) had standard 8 or lower, 17.3% indicated having standard 9, 34.7% indicated having matric/grade 12 qualification. Only 15.3% indicated having a college/technikon or university qualification. Two people did not respond to this item.

5.2.5 Dependents

The frequency distribution of those with or without children for the current study sample is presented in Table 5.5:

Table 5.5 Frequency distribution of Dependents

Categories	Frequencies	Percentage of people who Responded to this question (n = 100)
Children 9 years or younger	34	34.0%
Children 10 years or older	8	8.0%
No children	58	58.0%

As can be seen from Table 5.5, 34.0% of people who responded to this item (N = 100) indicated having child(ren) 9 years or younger, 8.0% indicated having child(ren) 10 years or older. A significant majority of 58.0% people responded not having children.

5.2.6 Duration of the Illness

The frequency distribution of Duration of Illness for the current study sample is presented in Table 5.6 below:

Table 5.6 Frequency distribution for Duration of Illness

Duration of Illness	Frequency	Percentage of people who Responded to this question (n = 92)
Less than a year ago	32	34.8%

Between 1 and 2 years ago	28	30.4%
More than 2years ago	32	34.8%
People who did not respond to this item	8	8.0%

As can be seen from Table 5.6, 34.8% of the people who responded to this item (N = 92) indicated being first diagnosed with HIV/AIDS less than a year ago, 30.4% indicated being informed of their HIV-positive status more than 2 years ago. 34.8% indicated being first diagnosed with HIV/AIDS more than 2 years ago.

5.2.7 Disclosure vs Non Disclosure

The frequency distribution of Disclosure vs Non Disclosure for the current study sample is presented in Table 5.7 below:

Table 5.7 Frequency distribution of Disclosure vs Non Disclosure

Have you disclosed your HIV status?	Frequency	Percentage of people who Responded to this question (n = 97)
Yes	83	85.6%
No	14	14.4%
People who did not respond to this item	3	3.0%

As can be seen from Table 5.5, an overwhelming majority of 85.6% of people who responded to this item (N = 97) indicated having disclosed their HIV-positive status,

14.4% indicated having not disclosed their HIV-status. Three people of the total sample (N = 100) did not respond to this item.

5.2.8 Person(s) to whom disclosure was made to

The frequency distribution of person(s) to whom disclosure was made for the current study sample is presented in Table 5.8 below:

Table 5.8 Frequency distribution of Person to whom disclosure was made

Person(s) to whom disclosure was made to	Frequency	Percentage of people who Responded to this question (n = 86)
Parents	53	61.6%
Spouse/Partner	51	59.3%
Child(ren)	30	34.9%
Friend(s)	50	58.1%
Family	67	77.9%
Media	8	9.3%
Co-worker(s)	17	19.8%
Supervisor(s)	5	5.8%

As can be seen from Table 5.8, 61% of people who indicated having disclosed their HIV-status (N = 86) disclosed to their parents, 59.3% disclosed to their spouse/partner, 34.9% disclosed to their child(ren), 58.1% indicated disclosing to their friend(s). A significant majority of 77.9% indicated disclosing to their family, 9.3%

indicated disclosing to the media, 19.8% indicated disclosing to their co-worker(s) and very few people indicated disclosing to their supervisor(s) (5.8%).

5.2.9 Sources of support for those who have disclosed their HIV-positive status

The frequency distribution of source(s) of support for the current study sample of those who have disclosed is presented in Table 5.9 below:

Table 5.9 Frequency distribution for Sources of Support for those who have disclosed

Source(s) of Support	Frequency	Percentage of people who Responded to this question (n = 86)
Parents	48	55.8%
Siblings	20	23.3%
Spouse/partner	40	46.5%
Friend(s)	52	60.5%
Colleagues	20	23.3%
Support Group	70	81.4%
Others	4	4.7%

As can be seen from Table 5.9, 55.8% of people who have disclosed their HIV-status in this study (N = 86) indicated receiving support from their parents, 23.3% indicated receiving support from their siblings, 46.5% indicated receiving support from their spouse/partner. A significant majority of people indicated receiving support from friend (60.5%), 23.3% reported receiving support from colleagues and an overwhelming majority of 81.4% reported receiving support from the support group.

Only four percent indicated receiving support from other sources than those indicated on the above.

5.2.10 Reasons for choosing not to disclose one's status

The frequency distribution of Reasons for not disclosing for the current study sample of those who did not disclose is presented in Table 5.10 below:

Table 5.10 Frequency distribution of Reasons for not disclosing

Reasons for not disclosing	Frequency	Percentage of people who Responded to this question (n = 17)
Fear of being ostracised	3	17.6%
Fear of being stigmatised	9	52.9%
Fear of losing my job	1	5.9%
Fear of what my children will think of me	3	17.6%
Fear of what my partner/spouse will say	3	17.6%
Fear of being rejected by my family	6	35.3%
Fear of being alone	8	47.1%
I don't believe that I am HIV positive	2	11.8%

As can be seen from Table 5.10, 17.6% of people who responded to this item (N = 17) indicated not disclosing because of fear of being ostracised, 52.9% indicated not

disclosing because of fear of being stigmatised, 5.9% indicated not disclosing because of fear of losing their job, 17.6% indicated not disclosing because of fear of what their children will think of them, 17.6% indicated not disclosing to their spouse because of fear of what their spouse/partner will say. A significant 35.3% of people indicated not disclosing to their family because of fear of being rejected by their family. A large majority of 47.1% indicated not disclosing because of fear of being alone. Only 11.8% of the total sample (N = 17) indicated not disclosing because they did not believe that they were HIV-positive.

5.1.11 Employment Status

The frequency distribution of Employment Status for the current study sample is presented in Table 5.11 below:

Table 5.11 Frequency distribution for Employment Status

Employment status	Frequency	Percentage of people who Responded to this question (n = 93)
Employed	20	21.5%
Unemployed (seeking job)	52	55.9%
Unemployed (not seeking a job)	21	22.6%
People who did not respond on this item	7	7.0%

As can be seen from Table 5.11, 21.5% of people of the total sample (N = 93) indicated being employed, a significant majority of 55.9% indicated being unemployed and seeking job, 22.6% reported being unemployed and not seeking a job. Seven people of the total sample (N = 100) did not respond to this item.

5.3 FREQUENCY OF RESPONSES TO ITEMS ON QUESTIONNAIRE

In order to get an overall view of how participants responded to individual items, an analysis was done on each item of the measurement instruments. The following sections will provide those analyses.

5.3.1 Frequency of responses on the IES-R scale

For clarity, although a five scale point was used, the information has been compiled in a three point format. The original point of scales which were “not at all” and “a little bit” were combined to give an indication of when participants responded that this item did not apply to them.

Furthermore, the same procedure was also done on the original point of scales which were “quite a bit” and “extremely” were combined to give an indication of when a participant responded that this item did apply to them.

The frequency distribution of responses on the IES-R for the current study sample is presented in Table 5.12 below:

Table 5.12 Impact of Event Scale Revised (IES-R)

Items		Did not apply	Moderately	Did Apply	Number of people who responded to this item
1. I had trouble sleeping at night	Number of responses	34	13	50	97
	%	35.0%	13.4%	51.6%	100.0%
2. Other things kept me thinking about my HIV-positive status	Number of responses	29	12	52	93
	%	31.2%	12.9%	56%	100.0%
3. I felt irritable and angry	Number of responses	36	18	40	94
	%	38.3%	19.1%	42.6%	100.0%
4. I allowed myself to get angry when I thought about my HIV-positive status.	Number of responses	43	13	39	95
	%	45.3%	13.7%	41.1%	100.0%
5. I thought about my HIV-positive status when I didn't even want to.	Number of responses	37	14	42	93
	%	39.8%	15.1%	45.2%	100.0%
6. I felt as if it did not happen or it wasn't real.	Number of responses	24	14	56	94
	%	25.5%	14.9%	59.6%	100.0%
7. I stayed away from anything that could remind me of my HIV-positive status.	Number of responses	31	13	50	94
	%	33.0%	13.8%	53.2%	100.0%
8. Pictures about my HIV-positive status came into my mind.	Number of responses	25	16	50	91

	%	27.5%	17.6%	55.0%	100.0%
9. I experienced shock.	Number of responses	26	8	53	87
	%	29.8%	9.2%	60.2%	100.0%
10. I tried not to think about my HIV-positive status	Number of responses	32	16	49	97
	%	33.0%	16.5%	50.6%	100.0%
11. I avoided dealing with my feelings.	Number of responses	26	17	52	95
	%	27.4%	17.9%	54.8%	100.0%
12. I felt numb about my HIV-positive status.	Number of responses	37	11	43	91
	%	40.7%	12.1%	47.3	100.0%
13. I found myself acting or feeling as though I was back at that time of hearing about my HIV-positive status.	Number of responses	32	17	43	92
	%	34.8%	18.5%	46.7%	100.0%
14. I couldn't fall asleep at night.	Number of responses	32	12	50	94
	%	34.1%	12.8%	53.2%	100.0%
15. I had mixed feelings about my HIV-positive status.	Number of responses	27	13	55	95
	%	28.4%	13.7%	57.9%	100.0%
16. I tried to remove the issue from my memory.	Number of responses	22	10	62	94
	%	23.4%	13.7%	66.0%	100.0%

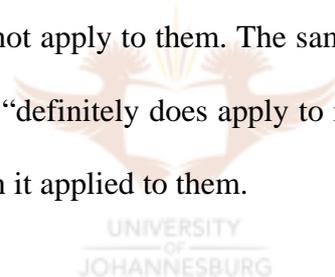
17. I had trouble concentrating.	Number of responses	39	10.6	42	93
	%	42%	12.9%	45.2%	100.0%
18. Anything that reminded me of my HIV-positive status caused me to have physical reactions, such as sweating, trouble breathing, nausea or a pounding heart.	Number of responses	32	14	46	92
	%	34.8%	15.2%	50.0%	100.0%
19. I had dreams about my HIV-positive status.	Number of responses	40	7	48	95
	%	42.1%	10.9%	50.5%	100.0%
20. I felt watchful or on guard.	Number of responses	31	11	49	91
	%	34.1%	12.1%	53.9%	100.0%
21. I tried not to talk about my HIV-positive status.	Number of responses	35	10	47	92
	%	38.1%	10.9%	51.1%	100.0%

As can be seen from Table 5.12, 56% of people who responded to this item (N = 97) reported that other things kept making them think of their HIV-positive diagnosis. A further 59.6% of the total sample of (N = 93) who responded to this item indicated feeling as though the experience of hearing news about their HIV-positive diagnosis was not real or it didn't happen. A significant majority of 60.2% of a total sample (N = 87) of those who responded to this item reported experiencing intense feelings of shock, 57.9% of those who responded to this item (N = 95) reported having mixed feeling about their HIV-positive status upon hearing news of their diagnosis. A large

majority of 66% from a total sample of (N = 94) of those who responded to this item indicated trying to remove the issue from their mind. Only 45% of a total sample of (N = 95) of those who responded to this item reported not experiencing feelings of anger after hearing news of their HIV-positive diagnosis.

5.3.2 Frequency of responses to items on the MAHIVS

Table 5.13 displays the pattern of responses on the MAHIVS. For clarity, although a four scale point was used, the information has been compiled in a two point format. The original point of scales which were “definitely does not apply to me” was combined with “does not apply to me” to give an indication of when participants responded that this item did not apply to them. The same procedure was also done on the original point which was “definitely does apply to me” was combined with “does apply” to me to indicate when it applied to them.



5.3.3 Frequency of responses to items on the MAHIVS

The frequency distribution of responses on the MAHIVS for the current study sample is presented in Table 5.13 below:

Table 5.13 Mental Adjustment to HIV Scale (MAHIVS)

Items		Did not apply	Did apply	Number of people who responded to this item
1. I have changed my diet to improve my health.	Number of responses	19	75	94
	%	20.2%	79.8%	100.0%

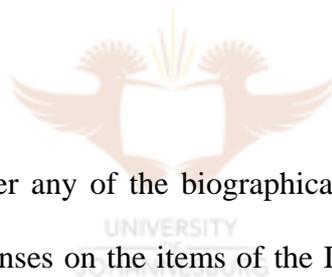
2. I can't do anything to cheer myself up.	Number of responses	47	45	92
	%	51.1%	49%	100.0%
3. Problems with my health prevent me from planning ahead.	Number of responses	50	43	93
	%	53.8%	46.3%	100.0%
4. I believe that my positive attitude will improve my health.	Number of responses	10	87	97
	%	10.3	89.7%	100.0%
5. I firmly believe I will get better.	Number of responses	18	79	97
	%	18.6%	81.5%	100.0%
6. I've left it all to my doctors.	Number of responses	45	50	95
	%	47.3%	52.7%	100.0%
7. I feel that life is hopeless.	Number of responses	52	44	96
	%	54.1%	45.8%	100.0%
8. I have been exercising to improve my health.	Number of responses	25	69	94
	%	26.6%	73.4%	100.0%
9. I've put myself in the hands of God.	Number of responses	11	86	97
	%	11.3%	88.7%	100.0%
10. I have plans for the future.	Number of responses	19	78	97
	%	19.5%	80.4%	100.0%
11. I feel that there is nothing I can do to help myself.	Number of responses	52	32	94
	%	66%	34.1%	100.0%
12. I try to carry on with my life as I have always done.	Number of responses	17	79	96
	%	17.7%	82.3%	100.0%

13. I make contact with others.	Number of responses	20	76	96
	%	20.8%	79.2%	100.0%
14. I suffer a great deal of anxiety about my HIV-positive status.	Number of responses	54	37	91
	%	59.4%	40.7%	100.0%
15. I take one day at a time.	Number of responses	25	66	91
	%	27.5%	72.6%	100.0%
16. I feel like giving up.	Number of responses	57	34	91
	%	62.7%	37.4%	100.0%
17. I try to keep a sense of humour about my HIV-positive status.	Number of responses	26	66	92
	%	28.3%	71.7%	100.0%
18. Other people worry about my HIV-positive status.	Number of responses	24	71	95
	%	25.3%	74.7%	100.0%
19. I keep busy so that I don't have to think about my HIV-positive status.	Number of responses	30	64	94
	%	31.9%	68.1%	100.0%
20. I avoid finding out more about my HIV-positive status.	Number of responses	51	43	94
	%	54.2%	45.8%	100.0%

As can be seen from Table 5.13, an absolute majority of 79.8% of those who responded to those who responded to this item (N = 94) indicated changing their diet to improve their health upon knowing their HIV- positive status. An astounding majority of 89.7% of those who responded to this item (N = 97) indicated believing that their positive attitude will improve their health, 81.5% of all who responded to this item (N = 97) reported believing that they get better. Another staggering majority

of 88.7% of those who responded to this item (N = 97) indicated putting their lives in God's hands, 82.3% reported trying to carry on with their lives as they always have. Of the total sample of (N = 96) of those who responded to this item, 79.2% reported making contact with other people, 72.6% indicated taking one day at a time. A significantly large majority of 71.7% indicated trying to keep a sense of humour about their illness, 74.7% of a total sample of (N = 95) indicated that others seem to worry about their HIV-positive status more than themselves. A significant 66.6% of those who responded to this item reported never feeling as though there's nothing they can do to help themselves.

5.4 IMPACT OF BIOGRAPHICAL VARIABLES ON IES, FS AND HS SCORES



In order to determine whether any of the biographical variables could have had an impact on participants' responses on the items of the IES and MAHIVS, the various groups' mean scores were compared with regard to the IES, Hopelessness and Fighting Spirit. These results are presented below.

5.4.1 Age

In order to establish whether participant's Age played a role in how participants responded on the IES, Fighting Spirit and Hopelessness a one-way ANOVA analysis was conducted. The following Table 5.14 shows the results of the ANOVA.

Table 5.14 ANOVA with regard to Age

Variable		Sum of squares	Degrees of Freedom	Mean square	F	Significance
IES	Between groups	0.823	3	0.274	0.305	0.822
	Within groups	57.630	64	0.900		
	Total	58.453	67			
Fighting Spirit	Between groups	0.441	3	0.147	0.366	0.777
	Within groups	31.721	79	0.402		
	Total	32.163	82			
Hopelessness	Between groups	2.756	3	0.919	2.091	0.108
	Within groups	33.839	77	0.439		
	Total	36.596	80			

As can be seen from Table 5.14, there were no gender differences between the Age groups with regard to their mean scores on the Impact of Events-Scale, Fighting Spirit and Hopelessness.

5.4.2 Marital Status

In order to establish whether participant's Marital Status played a role in how participants responded on the IES, Fighting Spirit and Hopelessness a one-way ANOVA analysis was conducted. The Table 5.15 below shows the results of the ANOVA.

Table 5.15 ANOVA with regard to Marital Status

Variable		Sum of squares	Degrees of Freedom	Mean square	F	Significance
IES	Between groups	0.559	2	0.922	0.303	0.739
	Within groups	63.460	69	0.922		
	Total	64.199	71			
Fighting Spirit	Between groups	0.049	2	0.025	0.063	0.939
	Within groups	32.917	85	0.387		
	Total	32.966	87			
Hopelessness	Between groups	2.077	2	1.038	2.326	0.104
	Within groups	37.060	83	0.447		
	Total	39.137	85			

As can be seen from Table 5.15, there were differences between group's Marital Status with regard to their mean scores on the Impact of Events-Scale, Fighting Spirit and Hopelessness.

5.4.3 Education

One-way ANOVA analyses indicated that there were no differences between the abovementioned education groups with regard to their mean scores on the Impact of Events-Scale and Fighting Spirit. However, responses seemed to differ between groups with regard to Hopelessness. The following Table 5.16 shows the results of the ANOVA.

Table 5.16 ANOVA with regard to Education

Variable		Sum of squares	Degrees of Freedom	Mean square	F	Significance
IES	Between groups	3.487	3	1.162	1.288	0.286
	Within groups	59.544	66	0.902		
	Total	63.031	69			
Fighting Spirit	Between groups	1.808	3	0.603	1.610	0.93
	Within groups	31.077	83	0.374		
	Total	32.885	86			

Hopelessness	Between groups	5.323	3	1.774	4.239	0.008
	Within groups	33.901	81	0.419		
	Total	39.224	84			

Multiple comparisons of this difference indicated that people in the groups “Standard 8 or lower” and “Standard 9” tended to have higher scores on Hopelessness than people in the group “Matric”. By using Sheffe’s test, a mean difference of 0.522 (“Standard 8 and lower” and “Matric”) and 0.609 (“Standard 9” and “Matric”) were found which was significant on the 0.05 level ($p = 0.032$ and 0.046 respectively).



5.4.4 Duration of Illness

One way ANOVA analysis indicated that there were no differences between groups’ Duration of Illness with regard to their mean scores on the Impact of Events-Scale, Fighting Spirit and Hopelessness. Table 5.17 shows the results of the ANOVA:

Table 5.17 ANOVA with regard to Duration of Illness

Variable		Sum of squares	Degrees of Freedom	Mean square	F	Significance
IES	Between groups	0.211	2	0.105	0.110	0.896

	Within groups	62.526	65	0.962		
	Total	62.763	67			
Positive attitude	Between groups	0.340	2	0.170	0.434	0.649
	Within groups	31.733	81	0.392		
	Total	32.073	83			
Hopelessness	Between groups	0.572	2	0.286	0.622	0.539
	Within groups	36.297	79	0.459		
	Total	36.869	81			

5.4.5 Employment Status

One-way ANOVA analysis indicated that there were no differences between the abovementioned age groups with regard to their mean scores on the Impact of Events-Scale and Fighting Spirit. However, responses seemed to differ between groups with regard to Hopelessness. The following Table 5.18 shows the results of the ANOVA.

Table 5.18 ANOVA with regard to Employment Status

Variable	Sum of	Degrees	Mean	F	Significance
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		squares	of	square		
			Freedom			
IES	Between groups	0.213	2	0.107	0.115	0.892
	Within groups	59.432	64	0.929		
	Total	59.646	66			
Positive attitude	Between groups	0.986	2	0.493	1.389	0.255
	Within groups	29.102	82	0.355		
	Total	30.088	84			
Hopelessness	Between groups	4.503	2	2.252	5.321	0.07
	Within groups	33.853	80	0.423		
	Total	38.356	82			

Multiple comparisons of this difference indicated that people in the group “Unemployed (not seeking a job)” tended to have higher scores on Hopelessness than people in the groups “Unemployed (seeking a job)” and “Employed”. By using Sheffe’s test, a mean difference of -0.655 (“Employed” and “Unemployed (not seeking a job)”) and 0.-0.472 (“Unemployed (seeking a job)” and “Unemployed (not seeking a job)”) were found which was significant on the 0.05 level ($p = 0.011$ and 0.035 respectively).

5.3.6 Children

Student's T-test indicated that there were no differences between the abovementioned groups with regard to their mean scores on the Impact of Events-Scale, Fighting Spirit and Hopelessness. The results are shown in Table 5.19 and Table 5.20 below:

Table 5.19 T-test results with regard to whether participants indicated that they had children younger than 10 years

Variable	T - statistic	Degrees of freedom	Significance
IES	-1.547	70	0.126
Positive attitude	0.976	87	0.332
Hopelessness	-1.742	85	0.085

Table 5.20 T-test results with regard to whether participants indicated that they had children younger than 18 years

Variable	T - statistic	Degrees of freedom	Significance
IES	-0.962	70	0.340
Positive attitude	0.741	87	0.460
Hopelessness	-1.413	85	0.161

5.4.7 Disclosure vs Non Disclosure

Student's T-test indicated that there were no differences between the abovementioned groups with regard to their mean scores on the Impact of Events-Scale, Fighting Spirit and Hopelessness. The results are shown in Table 5.21 below:

Table 5.21 T-test results with regard to whether participants indicated that they had disclosed their HIV status or not

Variable	T - statistic	Degrees of freedom	Significance
IES	-1.806	69	0.075
Positive attitude	1.790	86	0.077
Hopelessness	-0.001	84	1.000

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5.5 GENDER DIFFERENCES

In the following section the results for null hypothesis one and null hypothesis two will be discussed.

5.5.1 Gender differences with regards to the Impact of Events Scale Revised (IES-R)

In Chapter Four the following null hypothesis was stated:

Null hypothesis 1: There will be no significant differences between men and women diagnosed with HIV/AIDS in terms of their overall post traumatic symptoms in reaction to impact of event.

The above aspect is operationalised by measurement on the IES-R.

In order to test this hypothesis, Student's t-test was used to determine the difference between men and women with regard to their responses on the IES-R. The result is shown in Table 5.22 below:

Table 5.22 Significant differences in mean scores of men and women on the IES-R

Gender	Mean	Standard Deviation	Student's T-test results		
			t-score	Degrees of freedom (df)	Significance (p)
Male	2.476	0.009	1.022	70	0.310
Female	2.471	0.891			

As can be seen from Table 5.22, $P = 0.310$ which means that there is no significant difference between the mean scores of males and females on the IES-R. Therefore null hypothesis one cannot be rejected.

5.5.2 Gender differences with regard to the Mental Adjustment to HIV Scale (MAHIVS)

In Chapter Four the following null hypotheses were stated:

Null hypothesis 2: There will be no significant difference between men and women diagnosed with HIV/AIDS in terms of Fighting Spirit.

Null hypothesis 3: There will be no significant difference between men and women diagnosed with HIV/AIDS in terms of Hopelessness.

The above aspects were operationalised by measurement on the MAHIVS scale and its subscale of Fighting Spirit and Hopelessness. In order to test the hypothesis student t tests were used to determine the difference between male and female with regard to their responses on the MAHIVS (Fighting Spirits). The results are shown in Table 5.23 below:

Table 5.23 Significant differences in mean scores of men and women in terms of Fighting Spirit

Gender	Mean	Standard Deviation	Student's T-test results		
			t-score	Degrees of freedom (df)	Significance (p)
Male	3.408	0.450	2.122	87	0.037
Female	3.130	0.675			

As can be seen from Table 5.23 $P = 0.037$ which means that there is a significant difference between mean scores of males and females on the Fighting Spirit. This significant difference can be accounted for by a number of reasons most of which are discussed in the following chapter. Therefore the null hypothesis two can be rejected.

The following Table 5.24 contains results of the third hypothesis.

Table 5.24 Significant differences in mean scores of men and women in terms of Hopelessness

Gender	Mean	Standard Deviation	Student's T-test results		
			t-score	Degrees of freedom (df)	Significance (p)
Male	2.277	0.635	-1.161	85	0.249

Female	2.450	0.703			
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As can be seen from Table 5.24, $P = 0.249$ which means that there is no significant difference between mean scores of males and females in terms of Hopelessness. Therefore the null hypothesis three cannot be rejected.

5.6 CORRELATIONS

In order to test hypotheses four and five, Pearson product moment correlation coefficients were calculated to determine the relationship between the dimensions Fighting spirit and Hopelessness and Impact of Event. The results are shown in Table 5.25 below.

Table 5.25 Correlation matrix of the IES-R scale and the subscales of the MAHIVS

	Impact of Event Scale (IES-R)	Fighting Spirit (MAHIVS)	Hopelessness (MAHIVS)
Impact of Event Scale (IES-R)	1	-0.139 ($p = 0.257$)	0.390* ($p = 0.001$)

* Correlation is significant at the 0.01 level (2-tailed)

As can be seen from Table 5.18, IES showed no significant correlation with FS but a significant positive correlation with HS. This means that a person with a high score on Impact of Event will be likely to get high score on Hopelessness.

5.7 CHAPTER SUMMARY

In this chapter the current study findings were presented, with particular focus on variables that are pertinent to the current study. Therefore the following chapter will

attempt to put the above findings into perspective in relation to literatures reviewed in the current study.

CHAPTER SIX



DISCUSSION

6.1 INTRODUCTION

This chapter seeks to consolidate the current study finding with existing literatures on the topic. The discussion to follow will focus on the nature and composition of participants used in this study in terms of their biographical data and then followed by a discussion on the issue of disclosure versus non disclosure. Thereafter findings regarding differences between men and women in terms of their post traumatic symptoms in reaction to news of their HIV-positive diagnosis will also be examined. This will be followed by a discussion of the correlation between the experience of trauma symptoms, Fighting Spirit and Hopelessness. A brief discussion of HIV/AIDS in the South African context with regards to current study finding. Then the chapter will conclude by examining limitations of the current study and offer recommendations for future researchers.

6.2 Biographical data

In 2000, it was estimated that there were 2.5 million HIV-positive women aged 15 to 49 and 2.2 million HIV-positive men aged 15 to 40 in South Africa (Dorrington et al, 2001). The current study finding seems to correspond with the above assertion in that a majority of participants in this study were between the ages of 26 to 35. It was also not surprising to note that women were in the majority. According to recent research findings there is consistent growth in the number of women who are diagnosed with HIV infection in Africa and the Southern Africa (Harrison et al, 2000; Walker et al, 2004). A large majority of 65% of participants reported being single which further supports recent research findings which indicate that the youth seem to be more at risk of contracting HIV/AIDS (Walker et al, 2004). In terms of educational levels, a significant 32.7% of participants reported not having a matric certificate. Though a gender comparison was not conducted on this aspect, recent research findings discovered that women seem to have less access to education for example in 1995, it was found that 23% of African women aged 25 or more had no formal education, compared to 16% of African men (Foreman, 1999; Tlou, 2001).

Only 22% of participants reported being employed, a staggering 55.9% reported not being employed and seeking jobs. This issue of unemployment begs the question that has always been fiercely debated by the South African government regarding the role that poverty plays in the spread of HIV/AIDS. Foreman (1999) and colleagues argue that young African women are the poorest and most economically marginalised and least educated sector of the South African population (Tlou, 2001). This finding could perhaps apply to the current study participants.

6.3 Disclosure versus non disclosure

To disclose one's HIV-positive status to a partner seems to be one of the most difficult things people have to deal with in relation to HIV/AIDS (Gaillard et al 2000). An overwhelming majority of 83% of participants in the current study reported having disclosed their HIV-positive status to one or more of the following people; partner, parents, children, friend(s) or family. However, 14% of participants indicated that they have not yet disclosed their HIV-positive status, many identified fear of being stigmatised to be the main reason. This finding corresponds with that by Shabalala, 2001 whereby he found that HIV-positive women in Gauteng women who were interviewed in his study kept their HIV-positive diagnosis a secret for two or three years because of fear of being stigmatised. A study by Van Dyk & Van Dyk (2003) discovered that male participants who were single, with low academic qualifications and mostly living in rural areas of South Africa were more inclined to keep their HIV-positive status a secret.



Nevertheless, a large number of studies conducted between 1999 and 2004, including the current study, seem to reveal a stable pattern towards disclosing, which may be indicative of a gradual disappearance of stigma attached to HIV/AIDS and that communities appear to be becoming more knowledgeable about HIV/AIDS (Klevens et al, 1999; Shabalala, 2001; Van Dyk et al, 2003). This pattern towards disclosure of HIV-positive diagnosis may have implications for those who are diagnosed with HIV/AIDS in terms of accessing support which is believed to be crucial in improving mental well-being and instrumental in facilitating adjustment to the illness.

Both groups, namely, those who have disclosed and those who have not indicated receiving support from a number of sources. An overwhelming majority of 84% reported receiving support from the support groups. It is evident that support groups seem to play a crucial role in providing support to those diagnosed with HIV infection.

6.4 Reactions upon receiving news of HIV-positive diagnosis

Notification of HIV-positive diagnosis is usually followed by adverse psychological consequences, but the intensity, duration and specific characteristics of psychological response is likely to vary from person to person and many factors may influence the development of subsequent emotional reactions (Catalan et al, 1995).

Current study finding indicates that a total majority of 60.2% participants reported experiencing feelings of shock upon hearing news of their HIV-positive diagnosis. A significant majority of 66.0% of participants in this study indicated trying to remove news of their HIV-positive diagnosis from their mind. A total of 59.6% of participants reported feeling as though news of their HIV-positive were not real. The American Psychological Association (2000) argues that although exposure to catastrophic stress is a necessary condition, it is insufficient by itself to traumatise an individual. The critical denominator is the person's emotional response to such an event. Therefore, if an incident produces an intense emotional response characterised in the DSM-IV TR as fear, helplessness, or horror the event is considered to be traumatic.

Similar results were found in studies by Green (1990) and Stevens, et al (1997) whereby women who were diagnosed with HIV infection reported feelings of shock, fear, horror and helplessness upon hearing news of their HIV-positive diagnosis. Catalan et al (1995) postulate that the pattern of psychological reactions that can develop in response to the knowledge of a diagnosis of HIV disease is comparable to a range of reactions seen in other potentially life threatening conditions such as cancer. Responses to a diagnosis of HIV infection include in the first instance shock, denial, distress followed by gradual acceptance. Therefore it is evident that hearing news about one's HIV-positive diagnosis can be considered as traumatic, however it is not uncommon that not all participants experienced such news as traumatic.

Researchers and clinicians have observed that severe events like HIV discovery can produce epiphanies which refers to an interactional moments that leave marks on people's lives and have the potential for creating transformational experiences (Brodsky, 1995; Hall, 1994, Hassin, 1994, Jaffe, 1985). Researchers assert that there are a number of factors such as personality traits, cognitive style, gender and intelligence which may influence the way in which stressful events are perceived, appraised and processed (Horowitz, 1979; 2001, McFarlane et al, 1994, Raphael, 1986).

6.5 Gender differences regarding traumatic reaction upon receiving news of an HIV-positive diagnosis

In terms of gender differences regarding traumatic reaction to news of HIV-positive diagnosis in men and women the current study finding revealed that there were no

significant differences between men and women. A similar finding was reported by Fullerton et al (2001) whereby women did not differ from men in meeting the overall re-experiencing criterion of posttraumatic symptoms and PTSD after a motor accident. Though men and women in the Fullerton et al (2001) study reported the same frequency of posttraumatic dissociative symptoms, it is crucial to also note that these symptoms appeared to carry a different risk for PTSD in men and women, increasing the risk of PTSD significantly in women. This finding corresponds with that of Olley et al (2003) whereby they discovered that women in their study were more likely to suffer from PTSD.

If men and women appear to respond the same way to traumatic events how come then do women appear to be more at risk of developing PTSD than men. In response to the above assertion several studies suggested that risk factors such as a history of major depression and anxiety might explain the different rates for PTSD in men and women. However, Fullerton et al (2001) argue that those studies could not explain the higher rate of PTSD in women even if those factors and control for type of trauma were taken into account.

Researchers from developing countries argue that the majority of work regarding HIV/AIDS and psychological complications to date has been undertaken in the developed world. Given that in developing context women with HIV/AIDS may face greater stigmatisation and more previous and current negative life events than men, it is therefore possible that in these regions there is a concomitantly greater risk of psychopathology, maladaptive coping and disability among women (Lipsitz et al, 1994; Olley et al, 2003).

Literature indicates that most researchers agree that psychological and social factors may have important influence on mental health. However, there is still little consensus about the mechanisms linking social factors and the extent to which they can explain observed gender differences in mental health (Aspinwall et al, 2003; Connors, 1990; Eagle, 1987). Others argue that for more knowledge to emerge in this area researchers need to move beyond descriptive studies to studies that look in detail at the biological, psychological and social processes that influence health in general (Bach, 2000; Bar On, 1997). Kimerling et al (2002) allege that much remains unknown about gender differences in the diagnosis of PTSD. However, one consistent finding is that whereas men and women experience equivalent numbers of traumatic stressors across lifetime, women develop PTSD twice as often as men. This difference in prevalence may suggest two potentially fruitful areas of future research. First is the study of gender differences in both objective and subjective characteristics of traumatic stressors. Kimerling et al (2002) postulate that men experience greater exposure to life threatening accidents and witnessing of violence, whereas women experience more interpersonal violence in a form of domestic violence or rape. Across the sexes, traumas of “human design “ create greater risk for PTSD than events such as natural disasters or accidents, suggesting that women are likely to be at greater risk for disorder by virtue of the objective characteristic of traumatic experience they experience.

The above assertion may hold true especially in South Africa and the developing world. Barnett & Whiteside (2002) report that in South Africa, sex is often the site of routine violence and brutalisation. In 1998, for example, a total of 54 310 sexual

crimes were officially recorded though the actual figure was much higher. Violence against women is seen as a means of asserting power in relationships between men and women. Domestic violence which often goes unnoticed is also rife. Reports of men accusing their women for bringing HIV/AIDS into the family, in some instances even murdering them are not uncommon in South African newspapers nowadays.

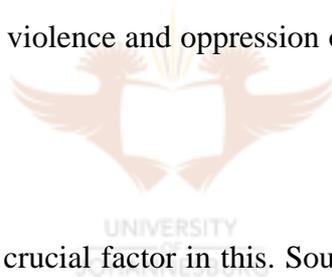
The second area that may prove fruitful in accounting for high risk of PTSD and other psychiatric morbidity in women after experiencing trauma may be attributed to cultural imbalances and differences between men and women. Bach (2000) asserts that in order to understand the meaning of gender differences in psychological responses to and the psychopathology associated with HIV/AIDS the issue of culture in which behaviour occurs need to be taken into account.

Cultures define and determine what is acceptable, unacceptable, normal and abnormal. Kimerling et al (2002) argue that it is therefore possible that gender role socialisation may impact the individual's understanding of symptoms associated with a traumatic event. Jewkes (2001) argues that in Southern Africa and Africa for women, all the norms that define acceptable behaviours, economic dependency and violence have been said to make them vulnerable to HIV/AIDS.

Be as it may be, women and men are exposed to different types of traumatic events, therefore, a gender-sensitive diagnosis of PTSD may need to include assessment of exposure to the full range of Criteria A events, including gender-specific events, such as miscarriage or breast cancer that might be associated with increased risk of

developing PTSD and consideration of the social and cultural context in which symptoms related to stress and trauma are experienced.

Although the impact of traumatic events has often been viewed in context of life threat, its effects on interpersonal relationship may also be important in terms of likelihood of developing PTSD. This focus on relationships may be due to the fact that all social relationships are characterised by unequal balance of power between men and women. Walker et al (2004) argue that in South Africa this balance is heavily weighed in favour of men. Men are better educated, earn more money than women, wield more power in society and have greater social status. Since 1994, these inequalities have been challenged by the state and the legal system. In spite of this, gender discrimination, sexual violence and oppression of women is rife (Walker et al, 2004).



Violence against women is a crucial factor in this. South Africa has the highest level of rape of any country not in a state war. Many women are infected through rape and are unable to get the drugs they need to help prevent HIV infection. Sexual violence in the home is wide spread. It is estimated that one woman in six is in an abusive relationship. For example, studies have indicated that up to 80% of women in rural areas have experienced domestic violence (Walker et al, 2004). This appears to be a huge problem because it may not be possible to negotiate safer-sex practices in abusive relationships rendering women more vulnerable to HIV infection.

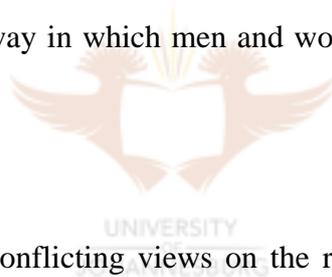
It can therefore be argued that the two areas for future research where gender differences in terms of risk factors to PTSD are concerned may be important in explaining this phenomenon.

The current study finding also found that there was a significant correlation between Impact of Event and Helplessness. In other words, a person who was found to have a high score on Impact of Event was more likely to obtain same high score on Helplessness. However, there was no significant correlation between Impact of Event and Fighting Spirit. Of significance regarding this finding is the fact no significant differences were found between men and women in relation to Impact of Event and Hopelessness. However, significant differences were found between men and women in terms of Fighting Spirit. Men appeared to have more Fighting Spirit than women.

According to the operationalisation of Fighting Spirit and Helplessness in the current study, Fighting Spirit is indicative of adaptive coping methods/mechanisms and Helplessness is associated with maladaptive coping methods/mechanisms. The current study finding can be set to have implications for coping. The current study finding is in contrast with that of Olley et al (2003) whereby they compared psychiatric morbidity, coping responses and disability in male and female outpatients recently diagnosed with HIV/AIDS. Olley et al (2003) found that women though were prone to meet diagnostic criteria for PTSD used coping strategies which included planning and religion which are usually construed as adaptive coping methods to deal with their illness. On the other hand, men were more likely to meet the diagnostic criteria for alcohol or dependence and engage in certain risky behaviours which are usually

associated with maladaptive ways of coping. Studies on coping have yielded mixed results.

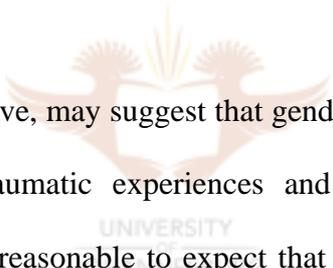
Some studies have found results consistent with socialisation hypothesis that men tend to use more problem-focused coping than women and women tend to use more emotion-focused coping (Billing & Moos, 1981; Folkman & Lazarus, 1980; Ptacek et al, 1992; Ptacek et al, 1994; Stone & Neale, 1984; Vingerhoets & Van Heck, 1990). In contrast, Parkes (1990) found that men used more suppression which refers to an emotion-focused measure characterised by restraint, withdrawal and ignoring the problem and equal amounts of direct coping referring to an active, problem-focused strategy as women were when dealing with adversities. However, other studies still found no differences in the way in which men and women cope (Hamilton & Fagot, 1988; Porter & Stone, 1995).



Regardless of the apparent conflicting views on the role of gender in as far as the issue of adjustment and coping is concerned Barlow (1988) presented an argument that might be instrumental in putting the current study finding into perspective. Barlow (1988) proposed that the perception of stressful events as unpredictable and uncontrollable is a psychological vulnerability that increases an individual's risk for developing and resorting to maladaptive coping methods which might predispose one to psychiatric morbidity. This perceptual style is likely based on a person's learning history and direct influences with stressors. Traditional sex roles may influence perception of and experience with stressor. Men are traditionally socialised to be more independent, masterful and assertive which is likely to increase their perception of controllability, whereas women are expected to display more passive and dependent

behavioural patterns that lead to the perception of uncontrollability over one's environment.

Barlow (1988) argues that coping styles that are consistent with traditional sex roles may influence the development of anxiety or panic disorders. He proposed that the incidence of panic and anxiety symptoms may be familiar among men and women, but that genders may differ in their primary method of coping with these experiences. Specifically, Barlow (1988) argued that perhaps it is more culturally acceptable for women to cope by expressing feelings of helplessness. In contrast, men may be more likely to use drugs or alcohol as a mean of avoiding their internal experiences which increases their risk of substance abuse than PTSD.



Evidence presented in the above, may suggest that gender differences appear to play a role in the coping with traumatic experiences and development of psychiatric morbidity. Thus, it might be reasonable to expect that men and women might differ significantly in their specific presentation of comorbidity with PTSD on symptom severity, course and functional impairment and perhaps better knowledge and understanding of these potential gender differences may inform and improve treatment delivery.

The current study finding brings to the fore factors that appear to be more relevant and applicable to the South African context. Therefore, the discussion to follow will attempt to put them into context in relation to issues that are confronting both the South African government and social science researchers working in the area of HIV/AIDS.

6.6 HIV/AIDS IN THE SOUTH AFRICAN CONTEXT AND THE CURRENT STUDY FINDING

South Africa, the rainbow nation and perceived by many as a land of contradictions. It is a nation filled with hope, endeavours, freedom and equality and yet a large part of the population is faced with grinding poverty, unemployment, the fear of violence and deeply entrenched cultural structures that may appear to support the oppression of millions of women. And then there is HIV/AIDS.

Poverty and disease (HIV/AIDS) are widespread in Southern Africa and are believed to major factors in the rapid spread of HIV and subsequent opportunistic infections. The disease mainly affects poor households in the region because breadwinners are ill or dying, the loss of income due to illness and medical and funeral expenses can be a devastating blow to an already desperate family. It may also pitch families that were just able to make ends meet into poverty (Walker et al, 2002; Marks, 2002; Skordis & Natrass, 2001). The current study finding supports the above assertion in that participants who were less educated and unemployed seemed to experience high significant levels of Hopelessness.

Bloom & Godwin (1997) maintain that the financial impacts of HIV/AIDS on households are as much as 30% more than those incurred by deaths from other causes. It is reported that HIV/AIDS has reached epidemic stages in South Africa and most African countries. It appears that HIV/AIDS is severely damaging the country. In fact it is estimated that although South Africa holds less than one percent of the world

population, it has ten percent of the world's HIV-positive population and 600 South Africans die every day from AIDS-related illnesses.

The majority of these people are between the ages of 15 and 35 as found in the current study (26-35 in majority), parents and children. When these estimates are further broken down, 44% of those infected worldwide are women, but in Africa this estimate increases to 55% of total infections, that is eight out of ten women infected worldwide are resident in Africa and the current study also attest to this finding in that there were more female participants. These figures refer to the fact that Africa and women, both with a history of marginalisation carry most of the world's HIV load. Within South Africa there are added complications to bear in mind. South Africa has a renowned legacy of institutionalised racial inequality. These inequalities are mirrored in the demographics of HIV/AIDS in the country today. Given a statistical background of the South African population, a significant number of them are African women further mirroring the historical inequalities that continue to characterise the nation.

Unfortunately, South Africa does not publish HIV figures according to race and this makes it difficult for the above assertion to be verified, however a number of studies can attest to this fact including the current one (Olley et al, 2003 Walker et al 2004; Van Dyk et al; 2003). It is apparent that women seem to bear the brunt of the HIV/AIDS in South Africa. Not only are they more vulnerable to infection but they also carry the burden of care for their families rendering them more at risk to psychological morbidities. The current study findings also seem to mirror these inequalities. Therefore understanding unequal gender relations and women's social standing are thus important aspects of making sense of HIV/AIDS in South Africa

context. Amid all of these, there is the government and its policies which do not seem to address the issue of HIV/AIDS with the kind of urgency it requires.

Efforts to address the HIV/AIDS epidemic have not resulted in smooth cooperation between different sectors of society. In fact the disease has exposed existing divisions. Government policy is set to differ from government practice. NGO disagree with each other and with donor agencies over effective interventions. Government appears to be in conflict with NGOs over implementation strategies. As recent legal and political battles between the Treatment Action Campaign and the South African government have demonstrated that civil society has been brought into direct confrontation with the state.

In the context of post-apartheid South Africa, state and non-state actors have clashed about how to define the problem, how to respond to it and who has the right to speak about it. Which civil society actors does the government chooses to work with is highly contested as is the extent to which civil society can inform government policy. To make matters even worse, when President Thabo Mbeki questioned the link between HIV/AIDS in 2000, he catapulted himself and the government into controversy and set the state on a collision course with HIV/AIDS activists (Schneider, 2002).

It can be argued that policies of the South African government seem to have become one of the major obstacles to an effective treatment programme in South Africa. What appears to have been a deliberate delay by the government to put in place necessary resources for the roll out of antiretroviral drugs raises a number of questions as to how much of the President's sentiments on HIV/AIDS impact on the government's attitude

and policies towards the issue of HIV/AIDS. Walker et al (2004) argue people who are diagnosed with HIV/AIDS appear not to have access to adequate health care facilities and AIDS seems to have aggravated this situation. Furthermore, hospitals and hospices in the formal health-care sector are increasingly unable to deal with the number of people who are ill or dying of AIDS-related illnesses. It is clear that the state would require an enormous outlay of capital and resources and a dramatic expansion of existing facilities if it were to take on this responsibility.

In an attempt to address this enormous burden, community-based care centres are mushrooming to try and respond to the crisis. Unfortunately due to inadequate funding these community-care centres rely on volunteers to provide emotional and practical support to households that are providing palliative care to sick and dying relatives Walker et al, 2004). The community-based care is premised on several assumptions. It assumes high levels of acceptance and low levels of stigma directed to those who are HIV-positive or sick from AIDS. It assumes that households are able to provide basic support and resources to the ill under their care. However, it is not easy to ask people who are living in desperate poverty to work for free, especially when there are well-resources operating in the area.

Community-based care programmes attempt to shift the burden of responsibility from hospices, hospitals, welfare organisations and other state institutions to poorly equipped and under resourced community organisations and households that are unable to cope. However, these community-based care programmes appears to have limited scope and capacity to do the work and are often unsustainable (Walker et al, 2004). There is also a concern about the quality of care that patients receive.

Moreover, there seems to be insufficient research documenting or analysing the impact and effectiveness of community-based care programmes. The current study finding seems to have provided such information since majority of participants in the current study were recruited from support groups which are a part of community-base care. Therefore, current study finding seems to indicate that the role that these community-based care plays is of great significance therefore need to be considered when policy issues regarding treatment programmes are discussed.

A study conducted in two sites, one in the village of Mpophomeni in KwaZulu-Natal and the other in Alexander township-Gauteng suggests that many of the assumptions about social and cultural context in which these programmes operate are inaccurate and invalid (Stadler, 2001). However, the current study finding seems to presents a slightly different picture from that painted above.

The above discussion addresses some of the problems and challenges that people who are diagnosed with HIV/AIDS in South Africa are confronted with on almost daily basis. Furthermore, what appears to be a conflict of interests between governmental policies on HIV/AIDS and HIV/AIDS activists most of which are positive themselves confound this matter even further.

HIV/AIDS like other life-threatening illnesses such as cancer and heart disease exact a tremendous physical and psychological price on their victims and others who are in the victim's social network. Not only will the person with HIV, cancer or heart disease have to worry about health complications and the possibility or inevitability of

dying, there may also be disruptions in relationships with family, friends, neighbours and people at work.

Living with HIV/AIDS however, presents unique problems that are not normally experienced by someone who has cancer or heart disease. Reactions to someone with HIV/AIDS as seen in previous chapters are influenced by cultural norms and social stereotypes. Furthermore, the rate at which people diagnosed with HIV/AIDS are dying in South Africa may cause those who already infected to experience more distress. Parents who are dying leaving behind children who are too young to fend for themselves, in fact two third of the 16.3 million children in South Africa are set to live below the poverty line. A fifth of children in South Africa do not live with their mothers.



It is estimated that by 2015 almost 12% of South African children will be orphaned as a result of HIV/AIDS (Walker et al, 2004). South Africa is seeing increasing numbers of children in distress, a situation made worse by the collapse of traditional models of child care such as the extended families (Tlou, 2001). Rising unemployment levels mean that fewer and fewer adults are in a position to provide for their household. Adults in the prime of their working lives are also vulnerable to HIV infection (Walker et al, 2002).

The challenge of living with HIV/AIDS in South Africa and Africa appears to be enormous and devastating. The above discussion outlined just a handful of issues that pertains to HIV/AIDS in South Africa. How does a person diagnosed with HIV infection living in South Africa expected to cope with the illness in the face of such

calamities? Literatures on coping assert that coping with HIV/AIDS will depend jointly on the personal and social resources available to the person, as well as on the stage of HIV infection and the medical and economic assets the person has to fight the disease at each stage (Folkman & Lazarus, 1980; Ptacek et al, 1994; Placek, Smith & Zanas, 1992). *As men were found to be more likely to show FS after being diagnosed, the question that begs to be asked is: what allows men in South Africa to respond to HIV diagnosis with more Fighting Spirit than women?*

Most of the conditions indicated in the latter as conducive for coping appear to be lacking among many of those who are diagnosed HIV-positive in South Africa according to the discussion above.

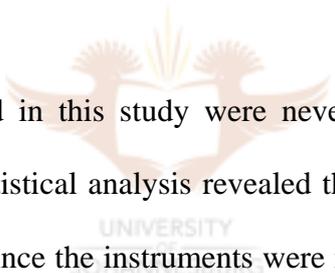
This raises a number of questions regarding the role that resiliency plays in coping. What role does adversity play in equipping and preparing one for future crisis? The following section outlines possible limitations of the current study.

6.7 LIMITATIONS OF THE CURRENT STUDY

There are a number of strengths and weaknesses that can be identified in the current study. One of the main limitations of this study is the relatively small sample size. Moreover the sample size of male participants which could be construed as having had consequent limitations in power to differentiate prevalence of reaction to trauma by gender. Due to the relatively small size the current study findings cannot be generalised to the entire population of HIV-positive individuals. Furthermore, almost

all participants came from support groups which may further limit the applicability of the findings to a larger population of HIV-positive individuals.

The current study sample composed of African men and women from townships around the Gauteng region which further limit the applicability of results to that particular region and making the applicability of research finding to other races difficult. However, the current study sample composition appeared to possess characteristics such as majority age group, dominant gender, low education levels and high unemployment rate that correlate with a number of studies conducted in South Africa making results useful and relevant to issues concerning HIV/AIDS in South Africa.



Research instruments utilised in this study were never standardised for the South African context, however statistical analysis revealed that they were reliable making current study finding valid. Since the instruments were not standardised for the South African context majority of participants who could not read or understand English were therefore excluded from participating.

Now that possible limitations of the study have been delineated it could therefore be argued that the current study finding achieved the aims for which the study was conducted which were as follows:

- Compare posttrauma reaction of men and women diagnosed with HIV/AIDS and attempt to account for the sameness or differences.
- To investigate how such reactions are likely to affect adjustment and progression of illness and whether there would be gender differences in coping

- To apply those results to the South African context

6.8 RECOMMENDATIONS

The current study's purpose was to investigate how men and women react to news of the HIV-positive diagnosis and how their reaction impact on the issue of adjustment to their illness. A number of important factors that are pertinent to the current study finding emerged. Therefore future researchers who may desire to explore the issue of HIV/AIDS and the role that gender play need to take into account the following:

- Gender dynamics are complex and seem to play a significant role in the shape and prevalence of the illness.
- These issues need to be understood in their complexity and responded to accordingly especially where issues of policy-making and treatment plan are concerned.
- There seem to be a deficiency in literatures regarding the phenomenological experiences of heterosexual men diagnosed with HIV/AIDS.
- Studies conducted on the issue emerge from studies that focused on gay/bisexual men most of which live in the First world countries and that raises concerns regarding the applicability of such studies to the South African context.
- Regarding the sample size, a larger sample would be more useful in that it will afford the researcher the opportunity to observe multiplicity of patterns which may exist in people of different race, socio-economic background and ethnicity.

- Due to the high rate of illiteracy in South Africa, a study utilising instruments that have been adopted and translated into at least two popular African languages may also be useful, considering that the epidemic is quite rife among poor communities most of which are illiterate.
- Support group treatment (policies and programmes).

6.9 CONCLUSION

The current study finding supports the importance of tailoring treatment and prevention messages to incorporate gender issues. Currently, it is evident that realistic strategies for treatment and protection for women are embedded in the social and gender-specific context of their relationship with men. Power imbalances seem to be the product of traditional gender roles which identify men as initiators and decision makers of sexual activities and women as passive gatekeepers whose job is to set the pace especially in Africa and South Africa. However, amid all the difficult challenges that men and women living with HIV/AIDS seem to be confronted with, there seem to be some implicit and subtle factors that appear to enable them to survive. Unearthing these factors may be of significance where the issue of treatment and prevention is concerned.

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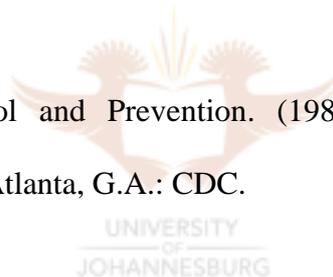
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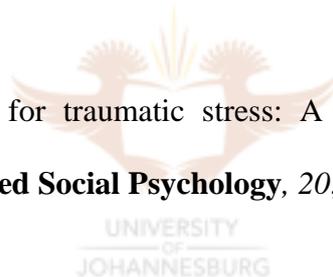
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