American Journal of Community Psychology, Vol. 19, No. 2, 1991

Brief Report

Psychological Frailness and Strength in an AIDS-Affected Community: A Study of Seropositive Gay Men and Voluntary Caregivers

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Addressed both the psychological frailness and strength in an AIDS-affected community. The gay community in Sydney, Australia, was represented by men who were seropositive (n = 60) and voluntary caregivers (n = 60). They were compared with two samples of men outside the gay community, who were ill with non-AIDS-related medical conditions (n = 30), and well (n = 30). Their psychological frailness and strength were measured by content analysis scales. Both the seropositive men and the caregivers showed the frailness of anxiety, indirectly expressed anger and helplessness, but also the compensating strength of greater personal competence and good feeling relative to the other men. The men who were seropositive or had other illnesses showed the predicted frailness of anxiety and depression but neither indirectly expressed anger nor helplessness. The seropositive men and caregivers of the gay community differed from each other only in the high levels of depression of the former.

Many members of gay communities have friends who have died from the acquired immune deficiency syndrome (AIDS) epidemic. Many are seropositive for the human immunodeficiency virus (HIV), with attendant relationship problems, fears for the future and supporting lovers and friends. AIDS has resulted in changes to their life-styles and their sexual practices. Since it was initially described among gay men, there has been an increase in their stigmatization (Herek & Glunt, 1988). However, these men have successfully mobilized their communities to reduce the spread of the virus

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0091-0562/91/0400-0279$06.50/0

(Kotarba & Lang, 1986). Yet this has not been without stress. The psychological frailness and strength to cope with this stress of seropositive gay men and gay men who provide care for those with AIDS are therefore examined in the paper.

Emotional states associated with other types of illness have been identified as forming a consistent pattern, which is responsive to psychological interventions (Viney, 1990). Some aspects of this pattern of frailness have been identified in men who are seropositive or have AIDS, especially anxiety (Holland & Tross, 1985), depression (Miller, 1987), indirectly expressed anger (Faulstisch, 1987), and helplessness (Namir, Wolcott, Fawzy, & Alumbaugh, 1987). We have found evidence of all these aspects of the pattern with seropositive men but also many perceptions of competence (Viney, Henry, Walker, & Crooks, 1989). Such evidence of psychological strength is important to the mobilization and maintenance of community resources in the face of such frailness.

One way gay communities have responded to the AIDS crisis is by forming self-help groups which organize voluntary care. This partly is a result of the perceptions of competence they seem able to maintain (Levine, 1988). Little is known of the psychological states of those who give this care. The literature exploring these states has so far consisted of personal accounts (Moffat, 1986). These accounts provide little information for meeting the psychological needs of voluntary caregivers in communities where the prevalence of AIDS is high, especially in providing much needed social support (Viney, Allwood, Stillson, & Walmsley, in press; Wolcott, Namir, Fawzy, Gottlieb, & Mitsuyasu, 1986).

In this study we examined the psychological frailness of members of the gay community who were seropositive and those who were voluntary caregivers, in comparison with men who were ill with other conditions and well. Their uncertainty, anxiety, depression, anger directly or indirectly expressed, and helplessness were assessed. The psychological strength of these men, including their perceptions of competence, good feelings, and sociability, was also monitored to test for any effects of their strongly supportive community. Although our study was essentially exploratory, on the basis of the community and health psychology literatures, we predicted that (a) men of the AIDS-affected community (seropositive and caregivers) would show both more frailness and strength than those outside it; and (b) men with illness (seropositive and other illnesses) would show more of the frailness of anxiety, depression, indirectly expressed anger, and helplessness than those with no illness.

METHOD

Research Participants

The main participants in this study were 60 seropositive men and 60 men providing care to those in the later stages of AIDS. They were all residents of Sydney, Australia. For inclusion in the seropositive group the men had to have tested positive to HIV antibodies. They were selected randomly from the numbered lists of such patients of three Sexually-Transmitted Disease Clinics. At the time of interview, they were Group II and Group III AIDS (Categories C and B), that is, in the early stages of AIDS. While many of them were experiencing some symptoms characteristic of HIV infection, none had yet been diagnosed with major infections due to poor functioning of the immune system. The ages of these men ranged from 21 to 58 (M = 35.92, SD = 7.29).

Men included in the caregiver group had been providing care (emotional support and/or physical nursing) to the AIDS-affected men of their gay community. They were selected randomly from the numbered list of members provided by their carer organization only if they did not report being seropositive. Their ages ranged from 23 to 64 (M = 37.62, SD = 8.78). Some men were caregivers because of involvement in voluntary care organizations; others were helping friends.

Two other groups of men outside the gay community, 30 male University students and 30 men experiencing non-AIDS-related illnesses, were included in the study to provide comparative data. The university students, all of whom were part-time and working full-time, had no signs of major illness. Their ages ranged between 23 to 43 years (M = 27.97, SD = 5.44), so that they were somewhat younger than the other groups. The fourth group had chronic, debilitating, or potentially fatal illnesses: diabetes, epilepsy, multiple sclerosis, and coronary conditions. They were selected, again randomly, from two hospital-based outpatient clinic lists. Their ages ranged from 24 to 46 years (M = 35.37, SD = 6.63). The nonparticipation rates for all of these groups were minimal.

Procedure

Confidential interviews with research participants took approximately 1 hour; and were conducted in a variety of locations of their choosing. The main locations for the first two samples were the participants' homes and

the AIDS Council of New South Wales offices. Early in all of the interviews a standard open-ended request was made: "I would like you to talk for a few minutes about your life at the moment, both the good things and the bad." With the permission of the participants, their responses to this request were recorded and transcribed. Counseling was offered to all except the student sample; however, all the data presented here are from interviews held before intervention.

Measures

To assess the extent of the mens' psychological frailness and strength, content analysis scales were applied to the transcripts. The method has been described in detail elsewhere (Gottschalk, Lolas, & Viney, 1986; Viney, 1983). The scales used have been employed to assess emotional reactions to a wide range of crises, and other stressful community-based events (Viney, 1981). In this study the interrater reliability of two independent, blind scorers for each of nine scales used were calculated for psychological frailness composed of uncertainty (.84), anxiety (.89), depression (.88), anger directly (.85) and indirectly expressed (.88), helplessness (.87), and for psychological strength composed of competence (.88), good feelings (.90), and sociability (.96). There were no significant differences in the levels of their scores as shown by t tests. Normative data and evidence of construct and criterion validity are provided in the references cited below.

Frailness. Uncertainty was measured by the Cognitive Anxiety Scale (Viney & Westbrook, 1976). It was designed to assess the emotion people experience when they have difficulty making sense of what is happening to them; and there is empirical evidence that it does so. References by the men to events that were unfamiliar to them (e.g., "I've never felt like this before") were scored on this scale. *Anxiety* was measured by the Total Anxiety Scale (Gottschalk, Winget, & Gleser, 1969). It is based on references to anxiety from a variety of sources such as death (e.g., "I could have been killed"), and separation (e.g., "I'm just so alone"). *Depression*, or anger turned in on oneself, was assessed using the Hostility In Scale, which recognizes statements indicative of self-blame, feelings of sadness and deprivation (e.g., "They don't give me the medication I should have"). *Directly expressed anger* was measured by the Hostility Out Scale, which was scored when the men expressed destructive and critical thoughts towards others and the world. *Anger indirectly expressed* was assessed by the Ambivalent Hostility Scale (Gottschalk, Winget, & Gleser, 1969), which measured projection of such anger. Perceptions of self as *helpless* were as-

Table I. Means, Standard Deviations, and Results of Univariate Analyses of Variance and Scheffé Tests for Each of Nine Psychological States by Group: Seropositive Men, Caregivers, Men with Other Illnesses, and Well Men

	Seropositive men (S)		Caregivers (C)		Men with other illnesses (I)		Well men (W)			
Psychological state	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	Univariate *F*(3, 176)	Scheffé contrasts
Frailness										
Uncertainty	1.14	0.71	1.07	0.65	1.42	0.62	1.19	0.64	1.99	S=C>I=W
Anxiety	2.17	1.22	1.99	0.76	2.66	0.75	1.46	0.60	8.99[b]	S=C>I=W S=I>C=W[b]
Depression	1.29	0.83	0.94	0.46	1.18	0.58	0.77	0.47	5.70[b]	S=C>I=W S=I>C=W[b]
Anger, direct	1.01	0.60	0.98	0.47	0.92	0.51	0.97	0.62	0.18	S=C>I=W
Anger, indirect	1.10	0.50	0.82	0.39	0.79	0.46	0.66	0.35	8.79[b]	S=C>I=W[a] S=I>C=W[b]
Helplessness	1.63	0.60	1.51	0.51	1.69	0.57	1.02	0.45	10.39[b]	S=C>I=W[a] S=I>C=W[b]
Strength										
Competence	2.83	0.89	2.80	0.73	1.21	0.41	1.09	0.33	7.02[b]	S=C>I=W[b]
Good feelings	1.44	0.71	1.36	0.56	0.94	0.43	0.58	0.28	19.65[b]	S=C>I=W[b]
Sociability	0.48	0.21	0.46	0.20	0.40	0.15	0.37	0.20	3.05	S=C>I=W

[a] $p < .05$.
[b] $p < .01$.

sessed by the Pawn Scale (Westbrook & Viney, 1980), which indicates when people attributed events to forces beyond their control. For this Scale, statements expressing lack of personal intention (e.g., "I never meant to get ill") and lack of ability (e.g., "I'm not much good at organizing") were scored.

Strength. Self as *competent* was measured by the Origin Scale which includes comments showing personal intention (e.g., "I mean to return to work soon") and ability (e.g., "I can do it if I want to"). The mens' expression of *good feelings* was measured by the Positive Affect Scale (Westbrook, 1976), with scoring of references to or implications of good feelings and contentment (e.g., "I enjoy life still, you know"). The Sociality Scale (Viney & Westbrook, 1979) assesses whether the men's current experiences included personal involvement in positive interpersonal relationships (e.g., "My friends are very supportive of me").

RESULTS

The data were initially subjected to a one-factor multivariate analysis of variance (MANOVA) which proved significant overall, multivariate $F(27, 500) = 5.45, p < .001$. To examine the impact of group membership, univariate analyses of variance (ANOVAs) were computed for each of the dependent variables, the results of which are provided in Table I. A priori comparisons with the Scheffé Multiple-Range Technique were used to test the specific predictions about group differences.

Significant univariate group differences were found for the frailness of anxiety, depression, anger indirectly expressed and helplessness, and the strengths of competence and good feelings. The results of the Scheffé contrasts between seropositive (S), caregivers (C), men with other illnesses (I), and well men (W) are available in Table I. As predicted, these contrasts indicate that the seropositive and the caregiver groups had higher levels of anxiety, indirectly expressed anger, and helplessness than the well group, but also higher levels of competence and good feelings. Men who were seropositive and had other illnesses showed more anxiety and depression than the well group.

DISCUSSION

Our hypotheses concerning the frailness and yet the strength of the men of an AIDS-affected community compared four groups: seropositive men, voluntary caregivers, men with other illnesses and well men. The first

hypothesis, contrasting the AIDS-affected community members with the other two groups received the most, although not complete, support. They proved to have the frailness of more anxiety, indirectly expressed anger, and helplessness but not depression. Yet they also expressed more competence and good feelings, but not significantly more sociality. The second hypothesis concerned only frailness, that of the two groups of ill compared with the well men. The former, as predicted, had more anxiety and depression, but not more anger or helplessness.

Much of the psychological frailness of the members of this AIDS-affected community took the form of anxiety, an important source of which was separation or alienation. As one seropositive man said: "I feel so alone. At work, if they found out, I'd be sacked, I'm sure." And a caregiver had a similar concern for his client: "Just seeing the way they treat him, it's like he really doesn't exist any more." The community members were frustrated and angry, but instead of expressing this directly it was disguised and projected elsewhere: "My brothers are pissed off with me about the AIDS." Both gay community groups also experienced considerable frailness in the form of helplessness in the face of AIDS: "Sometimes I wonder whether I am really much help to my client, because he's in such pain." However, the seropositive men were distinguished by high levels of depression: "I have no one but myself to blame for this." Fortunately, both these groups also experienced much that strengthened them. This was apparent in their expressions of competence, which showed purpose, energy, and a confidence in their ability to handle whatever occurred: "I'm going to do everything I can to keep this bug under control." This strength was also apparent in their sharpened ability to enjoy life in the face of the threat of AIDS: "If it's possible to say good things about AIDS, then it's made the gay community grow up: people really care for each other now."

The limitations of this study lie chiefly in the sampling of the groups. First, the caregivers who were selected may not have been so different in the important discriminating variable of being seropositive from the group that was described as seropositive. They may have tested positively and not reported it; they may have feared that they would test positively or imagined that they would. These considerations reduce the likelihood of differences being found between these two groups. Also, the men with other illnesses and the well men were not comparable on certain important variables with the AIDS-affected community men, for example, in terms of threat of death for the first group and age for the second. Any differences found between the groups, then, may have been due to these factors.

Our findings, tentative because of these limitations, are that AIDS-affected communities are likely to show considerable psychological frailness but that this may be compensated by strength. To assist them in dealing

with the distress of this frailness, they can use these strengths, which need to be enhanced and not undermined by psychological, educational, or medical interventions. The ability of their members to perceive themselves as competent and enjoy life should be fostered. At an organizational level, too, acting on their perceptions of competence should be facilitated by interventions that support rather than interfere with the self-help organizations they have established. Their participation in policy making and planning, too, should be encouraged.

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