



Coping strategies and social support after receiving HIV-positive results at a South African district hospital

Tin Myint, Bob Mash

To the Editor: Little is known in South Africa about patients' coping strategies when they hear that they are HIV-positive. Some are devastated, others seem hardly to react, and health workers also frequently report that their clients are in denial. Insight into how patients cope with such drastic news may help health workers to appreciate the different responses and be more supportive of patients' coping strategies.

The initial reaction to extreme bad news includes physiological, cognitive and emotional responses. Physiologically, people may experience symptoms of anxiety such as palpitations and sweating. Cognitively, they may manage to accept the reality, or indulge in blame, or find it difficult to believe the results; denial in the acute phase can be an acceptable way of coping.¹ Emotional responses may include anger, relief, guilt, shame or sadness. How a health worker breaks the bad news is an additional, important factor in the patient's ability to cope with it.

The ability to cope with change is related to the nature of the change, availability of social support, and personal factors.² The HIV rapid test provides results immediately, challenges the patients with life-threatening implications and complex lifestyle changes, and places high demands on their ability to cope. Social support can offer practical help, provide information, or help to contain and deal with strong emotions.² A close, supportive relationship can be a strong palliative factor, but depends on the patient's attachment style.¹ The extent to which people feel in control of their lives varies, and active coping strategies that enhance a feeling of control, such as task-focused coping or positive reframing, are beneficial.¹ Poorer adjustment is associated with persistent denial, venting of emotions, and behavioural disengagement that avoids dealing with change.¹ Poorer coping strategies and stress are associated with immunological deterioration and are likely to play a role in the strong connection between HIV and mental problems such as anxiety or depression.³ Coping has also been categorised as problem- or emotion-focused.⁴ Problem-focused coping aims at solving the problem or altering the source of the stress, while emotion-focused coping is directed at reducing or

managing the emotional distress associated with or caused by the situation. The degree of sickness and ability to understand and contain emotions, is also important.²

Methods

We measured perceptions of social support and the degree to which recognised coping strategies were utilised by patients after receiving an HIV-positive result, at Montebello District Hospital in rural KwaZulu-Natal.

All patients who attended for pre-test counselling over a 3-month period were invited to participate. During post-test counselling, those who tested positive and had previously consented were interviewed 2 weeks later. Patients were asked about characteristics such as age, sex, marital status and family history of HIV. They completed the Brief COPE questionnaire⁴ and the Multidimensional Scale of Perceived Social Support (MSPSS).⁵ We added further questions to explore the patient's perceptions regarding the counsellors who gave the bad news, based on the literature on how to break bad news effectively, and explored issues such as space to ask questions and obtain information, sensitivity to feelings, and the sense of being understood by the counsellor.

Ordinal data on the coping strategies were compared with continuous or ordinal variables, such as age or social support, using regression and the Spearman coefficient. Comparison with nominal categories, such as sex, were made using ANOVA (analysis of variance) and the *p*-value obtained from the Mann-Whitney or Kruskal-Wallis test as appropriate.

Results

Altogether, 120 newly diagnosed HIV-positive clients completed the interview. The majority of respondents were female (65.8%), aged 20 - 39 years (75.8%), single (66.7%), with 1 - 2 children (55.0%), black African (95.8%), Zulu-speaking (96.7%) and living in a rural area (92.5%). Most (90.0%) reported acquiring HIV from unprotected sex with a previous partner (59.2%), but others believed that they had been infected by their spouse (20.0%) or current partner (10.0%). Clients had often disclosed to family members (92.5%), but rarely to friends (0.8%) or others (3.3%).

Use of coping strategies was scored from 1 (not at all) to 4 (a lot). The most common strategy was obtaining emotional support (3.50, confidence interval (CI) 3.38 - 3.63) from someone else. Accepting that they really were HIV-positive (3.15, CI 2.80 - 3.27) and advantageously reframing the situation (3.00, CI 2.91 - 3.10) were the next most common



strategies. Following these, clients turned to religion (2.99, CI 2.12 - 3.19) and engaged with active coping (2.68, CI 2.59 - 2.78) and planning (2.64, CI 2.54 - 2.75). Clients also sought instrumental support by asking for information, advice or assistance (2.39, CI 2.31 - 2.48). Others turned to self-blame (2.37, CI 2.31 - 2.61), distraction by other activities (2.25, CI 2.15 - 2.36), humour (2.03, CI 1.79 - 2.27) or substance abuse (1.93, CI 1.80 - 2.07). Only a minority became disengaged (1.65, CI 1.53 - 1.77), vented their emotional distress (1.55, CI 1.45 - 1.64) or denied the reality of their infection (1.14, CI 1.07 - 1.21).

Perceived social support was scored from 1 (not supportive) to 7 (very supportive). Counsellors (6.94, CI 6.91 - 6.98), partners or spouses (6.51, CI 6.40 - 6.62) and family members (6.47, CI 6.30 - 6.63) were found to be very supportive. Friends were scored much lower in terms of their social support (3.50, CI 3.10 - 3.91).

Women ($p=0.01$), widows ($p=0.01$) and younger people ($p=0.03$) turned to religion more than other categories of sufferers. Younger people relied on emotional support as a coping strategy more than older people ($p=0.00$). Those who had children were more likely to use acceptance as a coping strategy ($p=0.02$). Those who disclosed to family members turned to emotional support and positive reframing significantly more as a coping strategy ($p<0.01$). Those who believed they were infected by their previous partner, reported emotional support as a coping strategy more than those who believed they were infected by their current partner ($p=0.01$).

There was a significant association between perceived social support from family or 'significant others' and the use of emotional support and positive reframing as coping strategies ($p=0.00$). There was a significant association between social support from families and religion as a coping strategy ($p=0.02$). Social support from friends had a different set of associations including distraction ($p=0.03$), venting ($p=0.01$), humour ($p=0.02$) and acceptance ($p=0.02$) as coping strategies. Counsellors were not associated significantly with any coping strategy except emotional support ($p=0.00$).

Discussion

Patients mostly utilised active coping strategies involving emotional support, acceptance, positive reframing and planning. Avoidance coping strategies, such as disengagement, substance use and denial, were in the minority. Many patients turned to religion to cope, which might have helped them to find meaning and spiritual support.

Most patients had disclosed their status after 2 weeks and reported emotional support as their commonest coping strategy. In contrast to other studies,¹ emotional support was largely derived from families and 'significant others' as opposed to networks of friends. Patients were reluctant to disclose to their friends, presumably because of the fear of stigmatisation and loss of confidentiality.

Emotion-focused strategies were ranked higher than problem-focused ones, presumably because the underlying problem of HIV cannot be cured or removed as a source of stress.

These results (after 2 weeks) cannot predict what coping strategies will be used later or in response to other stressful events. Nevertheless, many studies have shown that the way individuals cope while living with HIV/AIDS affects their emotional and physical well-being and their quality of life.⁶ These findings reinforce the valuable role that counsellors play in addressing patients' needs for emotional support and how they initially cope with the diagnosis of HIV.

References

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