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Title: A Study from Uganda: HIV Causal Attributional Structuring, Negative Affect, and Coping Among People with HIV/AIDS

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Note. The following article was authored by Dr. Peter Kakubeire Baguma, Institute of Psychology, Makerere University, Kampala, Uganda, and is extremely timely for three reasons. First, AIDS continues as a pandemic, and culturally relevant theory and data continue to be crucial in developing primary, secondary, and tertiary intervention strategies. Second, AIDS continues as a global security issue with implications for economics, politics, governmental stability, and war and peace. The psychology of AIDS bears on this issue and implications. Third, Baguma's efforts are an example of the research that must be shared synergistically among an international electronic community if the pandemic and its security consequences are to be satisfactorily resolved.

Abstract. Weiner's attribution theory suggests relationships between attributions, emotions, coping, and behavioral consequences (Weiner, 1986, Amirkhan, 1990). Studies supporting the theory are still limited especially in the health area and AIDS in particular.

The present study aimed at assessing relationships between HIV causal attributional structuring, negative affect, and coping among people with HIV/AIDS (PWA). A sample of 217 PWA and 119 patients suffering another disease were interviewed regarding HIV attributions, dimensional structuring, negative affect, and coping ways. Percentages, chi-square, factor analysis, Pearson correlation, t-test and regression were used to analyze the data. The majority of PWA attributed HIV infection to spousal behavior and involvement in sex due to the needs for financial support, love, strong sexual urge and to loose sexual habits. Extramarital sex and promiscuity in general were also reported as other factors responsible for the participants contracting HIV. PWA scored significantly higher on the dimension of stability but significantly lower on external control compared to the non-AIDS group. PWA scored higher on all negative effects. Five coping factors were identified, and significant relationships were found between dimensions, negative affect, and coping behavior.

Introduction

Weiner's attribution theory of motivation and emotion states that negative outcomes and important, sudden, or unexpected events initiate attributional search aimed at explaining why they occurred. The attributional process is a sequential process stemming from outcome evaluation to causal antecedents, to causal ascriptions; to causal dimensions; and, finally, to expectancy and emotional experience which together determine action. The actions might be in any motivational domain, e.g., achievement or affiliative, and can be described according to their intensity, persistence, latency, and amplitude (Weiner, 1974, 1979, 1986, 1992; Wong and Weiner, 1981). Weiner's attribution theory has been applied in many areas including education, sports, health, and coping (Amirkhan, 1990).

Weiner (1986) identified outcome-dependent, attribution-independent affects as those that are determined by attainment or non-attainment of an outcome but not by the cause of that outcome. These include emotions like frustration, happiness, and sadness (i.e., general positive or negative emotions). Thereafter, attribution-dependent emotions follow. This happens when causes are

considered (determined by the perceived cause of the prior outcome). This consideration follows causal dimensions that include locus, stability, and controllability. Weiner (1985) proposed that locus of causality influences esteem related emotions, e.g., pride, confidence, feelings of competence, dissatisfaction, incompetence, and shame. Controllability has been linked to social emotions, e.g., anger, pity, gratitude, guilt, shame and blame. Stability has been linked to hopefulness (or hopelessness), resignation, and fear. Weiner (1986) suggested that two causal dimensions may be combined to influence an emotional reaction, e.g. internal and uncontrollable causes lead to shame, and guilt is felt when causes are perceived as internal and controllable.

There is every reason to believe that the attribution theory can be applied to HIV/AIDS. HIV/AIDS is one of the most stressful (negative) events in the World today. It is a chronic, stigmatised disease that is likely to lead to causal search. This causal search is likely to influence the emotions, coping, and psychological distress among the people with HIV/AIDS.

Research reports point to the fact that attributions may influence the type of coping exhibited (Parkes, 1984; Rotter, 1966). Parkes' study investigated stressful episodes reported by 171 female student nurses in England and indicated that patterns of coping reported by internals were potentially more adaptive than those of externals. Amirkhan (1990) suggested that, if the cause of the problem is seen to be controllable, a greater intensity and persistence in behavior will ensue than following uncontrollable causes. Ganellen and Blaney (1984) found that uncontrollability of a stressor was linked to less coping effort, lower motivation, and less persistence in coping. Furthermore, Baumgardner, Heppner, and Arkin (1986) found that students who attributed adolescent problems to internal, unstable, and controllable causes tended to use instrumental responses and showed more persistence in coping. Those who perceived causes of hassles as controllable showed active, instrumental coping and events as having stable, global causes, were rated more bothersome--creating feelings of frustration and helplessness--and produced avoidance forms of coping (withdrawal and use of distraction).

The role of attributions in medical settings has also been explored. Bulman and Wortman (1977) applied the attribution approach and interviewed 29 people who were either paraplegic or quadriplegic and used semi-structured questions centering on why they had the disease. In addition, the staff at the institution rated each individual on how well he or she was coping with paralysis. Out of the sample, 96.6% gave a reason for their condition and considered the question important. This percentage was further evidence that people make attributions to explain occurrence of health problems. Bulman and Wortman (1977) also provided evidence regarding the relationship between coping and attributions. Their results showed that people who blamed themselves for the accident, but who felt they could not have avoided it, were the best in coping. Later on, Bulman and Wortman (1979) [as reported by DuCette and Keane (1984)] found that patients' explanations for their illness and their experiences following surgery were related to their rate of recovery. The conclusion here is that patients in critical health situations generate reasons for their condition, and these causal explanations affect their ability to cope with the disease.

Studies addressing AIDS from an attributional perspective. Wiener's (1992) points out that people might know the cause of AIDS. For example, 80-90% of Ugandans are well-informed about AIDS and its causes). However, the question of why the person was infected in the first place is very important. His study focused on the dimension of controllability and examined whether AIDS patients are held personally responsible for their plights. Weiner, Perry, and Magnusson (1988) asked students in both the USA and Canada the extent to which individuals are personally responsible for various stigmas like Alzheimer's disease, blindness, cancer, heart disease, paraplegia, Vietnam war syndrome, AIDS, child

abuse, drug abuse, and obesity. Results indicated that AIDS was perceived as similar to other behavioral stigmas (child abuse, drug abuse, and obesity) in terms of assigned responsibility and different from the other somatic stigmas including blindness and cancer which elicited much weaker perceptions of personal responsibility. Controllable causes of AIDS increased ratings of responsibility, while uncontrollable causes received reduced ratings. This was true with other stigmas.

Relating causes to affects, Weiner, et al. (1988) showed that AIDS elicited much anger and less pity than the other somatic stigmas, although it evoked more positive reactions than child and drug abuse. Causal attributions of AIDS were related to cognitive reactions and to affective consequences such that causal connections of AIDS to drug abuse and homosexuality were seen as controllable (person is responsible), leading to feelings of anger. The fact that AIDS can be transmitted led to feelings of anger and fear, and perceiving the cause as immoral led to anger and disgust, but the fact that AIDS is terminal led to feelings of sympathy and pity. Attributions of controllability lead to anger and were associated with neglect in terms of pro-social behavior. The attributions of uncontrollability lead to sympathy and pity and this was likely to lead to help-giving.

Using vignettes among students to manipulate the onset and offset responsibility, Weiner et al. (1988) indicated that PWA not responsible for the onset of AIDS were not blamed as they tried to cope. Instead, pity was expressed by the observer. Those responsible for onset of AIDS were blamed, and this blame was not altered by good or poor coping of the PWA. This research shows that attributions influence cognitive as well as emotions in observers.

The study of Folkman, Chesney, Pollack and Coates (1993) related attributions (controllability) to AIDS-related distress. In the study, stress-appraised control (attribution) and coping among 425 HIV- positive and HIV-gay men were assessed. Results indicated that appraised control (attribution) and stress and coping accounted for 10% of the variance in depressive mood. However, the attributions were not measured explicitly.

There is lack of information on research that has applied the attribution theory to HIV/AIDS. The associations between HIV/AIDS causal attributions, antecedents, ascriptions, causal structure, negative affect, and coping are not clear. With this information missing, psycho-social interventions aimed at reducing negative affect, coping problems, and psychological distress among the PWA cannot be designed.

Hypotheses. Nine hypotheses were set to guide the research: Hypothesis 1: The majority PWA would report HIV infection causal attributions; Hypothesis 2: PWA compared to the non-AIDS group would score significantly different on dimensions; Hypothesis 3: The PWA group compared to the non-AIDS group would score higher on negative affect; Hypothesis 4: Causal dimensions would influence negative affect such that there would be a significant positive correlation between locus and negative affect measures; Hypothesis 5: Higher scores on stability would significantly be associated with higher negative affect; Hypothesis 6: Higher scores on personal control would significantly be associated with increased negative affect; Hypothesis 7: Higher scores on external control would significantly be associated with increased negative affect; Hypothesis 8: PWA would mainly exhibit emotion-focused coping; Hypothesis 9: Both dimensions and negative affect would predict coping.

Methodology.

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Sample. A two-group, descriptive-survey design was used. The sample comprised of 217 PWA identified with the help of the Traditional and Modern Health Practitioners Together Against AIDS organization. The majority of the healers were registered with this organization and made the identification of PWA easier. All the PWA attending treatment by selected healers were recruited for study (because of fewer numbers of PWA involved per healer). A control group of 119 patients attending traditional healers for a non-AIDS disease (bewitchment) was purposively selected for comparison. The two groups were similar on education and other socio-economic status variables.

Procedure.

The actual data collection was preceded with a pilot study that aimed at improving the reliability and validity of the instruments. Other uses of the pilot were to assess problems likely to be encountered and their magnitude, gaining access, and assessing the locations of healers. Actual data collection involved administration of structured interviews to the PWA.

The assessment of PWA started with background factors and, thereafter, attributions were elicited. PWA were asked about attributions regarding to what led them get HIV. This was assessed by an open-ended question: "When people get a disease, they ask themselves about the possible causes; in your case, what do you think caused you to get HIV?" The responses were recorded verbatim. This procedure was based on Taylor, Lichtman and Wood (1984) who used the same method to elicit causal attributions among breast cancer patients.

Regarding the dimensional structuring of causes, the participants were asked to think about the responses (causes) given above and were requested to rate each of them on 12 items based on the Causal Dimension Scale (Russell, 1982: revised). This scale measures causal dimensions of stability, locus, and controllability. In this revised scale, the dimension of controllability is separated into two parts: namely personal control and external control. Therefore, the scale had 4 subsections as follows: external control was made up of items 5, 8, 12 and had a reliability "SYMBOL 97" of 0.73. Stability subsection had items 3, 7, 11 (reliability = 0.54); the personal control subsection had items 2, 4, and 10 with a reliability of 0.76. The locus sub-scale had items 1, 6, and 9 and had reliability of 0.70. In all cases, a high score meant high stability, high personal control, high external control, and high locus.

The self-report method recommended by Weiner (1996) was used to assess negative affect. The reliability of the scale that measured negative affect was 0.70. The participants were asked to indicate whether or not they felt the following negative affects: guilt, regret, self-blame, and shame. Response alternatives were Yes or No being recoded as 1 and 2, respectively. Those who indicated that they felt any of the negative affects were requested to indicate the extent of such feelings. Response alternatives ranged from a little to very intense, being recoded as 1 through 4, respectively. In this way, each participant got a score on the felt negative affect. A small score indicated reduced feeling and a high score indicated intense feeling of the affect.

The disease status of the PWA was assessed to re-ascertain their sero-positivity. The participants were asked to indicate their sero-status, and the year they learnt about it--i.e., how long since knowledge of infection. In addition, the participants were asked whether they had experienced any of the 13 AIDS-related symptoms "SYMBOL 97" = 0.63). Response alternatives were Yes or No being recoded as 1 and 0, respectively. Yes was scored as 1 and scores were added to give the total score on symptoms. These questions had been used on homosexual and bisexual (HIV positive and HIV negative) populations by

Folkman, Chesney, Pollack, and Coates (1993) but were adapted to the Uganda clinical definition of AIDS.

Next, the PWA were assessed on how they coped with AIDS. Coping with AIDS was assessed using the 48-item Ways of Coping Scale ("SYMBOL 97" = 0.93) based on Folkman and Lazarus (1980) and was adapted for measuring coping with AIDS by Taylor et al. (1992). Some items were reworded, and others added to improve the scope of coping mechanisms to make the scale more specific to the Ugandan situation. This increased the items up to 53. The participants were asked to rate on a 4-point scale the extent to which over the past month they had used 53 methods of responding to the problem of AIDS. Response alternatives ranged from not at all to a great deal being recoded as 1 through 4, respectively. Furthermore, the PWA indicated if they had been counseled, and if so, how and for how long and the number of times they had been counseled. Responses were recoded as given.

The control group comprised patients who were consulting traditional healers for a non-AIDS disease. These patients were asked the same questions as those asked to PWA, except questions that referred to AIDS directly. In that case, the questions were rephrased to refer to the particular disease one had. Steps were taken to make sure that participants in this category did not suffer from AIDS too, e.g., by interviewing them on their medical history and symptoms.

Data analysis.

Data obtained were entered in the computer under the SPSS program and preliminary analyses of frequencies, reliability checks, and debugging were done. Frequency checks are particularly good for examining whether data were sensibly scored and entered into the computer in the right way. Factor analysis of the Ways of Coping Questionnaire then followed. Percentages, chi-square, and Pearson correlation, t-test and regression were used to test the hypotheses.

(Note: The conclusion of this article including Dr. Baguma's Results and Discussion sections will be posted in the February 23rd Issue of IBPP. There are two reasons for this: (1) To allow readers ample time to generate their own predictions about the findings; (2) To allow IBPP ample time to generate the best possible approach (web-presentation) for depicting the 12 tables developed by Dr. Baguma.)

(See Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and Reformulation. *Journal of Abnormal Psychology*, 49-74; Amirkhan, J. H. (1990). Applying attribution theory to the study of stress and coping. In S. Graham & V. S. Folkes, (Eds). *Attribution theory, Application to achievement, mental health and interpersonal conflict*. Lawrence Erlbaum; Aldwin, C., & Revenson, T. A. (1987). Does coping help? A re-examination of the relationship between coping and mental health. *Journal of Personality and Social Psychology*, 337-348; Antoni, M. H., Schneiderman, N., LaPierriere, A., J., Sullivan, M., Marks, J., Efantis, J., Skyler, J., & Fletcher, M. A. (1992). Mothers with AIDS. In P. I. Ahamed, (Ed.). *Living and dying with AIDS*. Plenum Press; Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ, Prentice Hall; Baumgardner, A. H., Heppner, P. P. & Arkin, R. M. (1986). Role of causal attribution in personal problem-solving. *Journal of Personality and Social Psychology*, 636-643; Beck, A. T. (1985). *Anxiety disorders and phobias: A cognitive therapy of depression*. Guildford; Bradbury, T. N. & Fincham, F. D. (1990). Attributions in marriage: Review and critique. *Psychological Bulletin*, 107, 3-33; Brisket, M. & Nowicki, S. Jr. (1973). Internal versus external locus of control of reinforcement and reaction to frustration. *Journal of Personality and Social Psychology*, 25, 35-44; Bulman, R. J. & Wortman, C. B. (1977). Attribution of blame and coping in the "real world": Severe accident victims react to their lot. *Journal of Personality*

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