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CARFAX

Subjective HIV attribution theories, coping and psychological functioning among homosexual men with HIV

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Abstract *Facing a traumatic event, such as being diagnosed with HIV, the individual tries to find an explanation why the traumatic event happened. One way to answer that question is through attributions. The purpose of this study was to examine subjective attribution theories for HIV (internal/self-blame, external/blaming others, and fatalistic) and their association with coping styles and psychological functioning among 57 self-defined gay men who were HIV-positive. None of the respondents were diagnosed with AIDS. Although all men made attributions for their HIV infection, few had incorporated exclusively self-blame and external attributions, respectively. About one-third of the gay men attributed HIV to both self-blame and external factors. Self-blame attribution was associated with the avoidant coping style. Analyses yielded that both self-blame attribution and the avoidant coping style correlated with depressive mood and life dissatisfaction. External attribution theory displayed a positive relation to depressive mood. No particular HIV attribution theory was tied to good psychological functioning. The clinical implications of these results are discussed.*

People formulate their own assumptive worlds (Janoff-Bulman, 1989) or 'a working model of the world' (Bowlby, 1969) to make sense of the world around them and their place in it. Facing a traumatic event, such as being diagnosed with HIV, the individual's assumptive world may be shattered. The basic cognitive challenge of a trauma is to restore the basic, implicit assumptions the person held about himself or herself and the world prior to the traumatic event (Janoff-Bulman & Frieze, 1983). One aspect of this readjustment process is the search for meaning in the adverse experience (Taylor, 1983). Another way to put it is the individual's psychological need to find an explanation why the traumatic event happened. One way to answer that question is through attributions.

Attribution theory (Kelley, 1967) states that following a threatening or dramatic event, people will make attributions so as to understand, predict and control their environment (Wong & Weiner, 1981). These psychological explanations of an illness can be attributed to the self, some other person, the environment, or chance. Self-attribution can, in turn, be separated into behavioural self-responsibility for 'cause' and self-blame (Zich & Temoshok, 1988). Self-blame attributes cause to self with an added self-punitive element.

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With respect to the concept of self-blame, Janoff-Bulman (1977) makes a distinction between self-blame attributed to behavioural or characteriological factors. Behavioural self-blame is assumed to be situational related. Further, the individual views his or her own behaviour as a contributing factor to their misfortune. In doing so, the individual experiences a sense of control, rather than helplessness and passiveness, and thus maintains his or her self-esteem and psychic stability intact. From a psycho-dynamic perspective, behavioural self-blame can be viewed as a protector of the narcissistic equilibrium (Clement, 1992). When self-blame is of a characteriological character the misfortune or trauma is subjectively perceived as proof of the individual's character, shortcomings, flaws, and/or consistent bad luck. Under such conditions, the narcissistic equilibrium and the individual's self-esteem are heavily attacked and violated. As a consequence he or she may experience psychological distress. Self-blame attributions are of particular interest when it comes to gay men who are HIV-positive. HIV infection has been associated with personal responsibility, blame and 'the guilty' since it was first labelled as the 'gay plague' in the early 1980s and with negative moral connotations associated with homosexuality and venereal diseases.

Taking into consideration the empirical evidence for ill people's need for explanations of their illness (Taylor, 1983), as well as correlations between attributions and psychological functioning, (Becker, 1986; Bulman & Wortman, 1977; Mastrovito, 1974; Taylor, 1984; Weisman, 1975) it is noteworthy that minimal research has paid attention to these issues among people with HIV/AIDS. While various studies (Barrett, 1989; Christ & Wiener, 1985; Dilley *et al.*, 1985; Hirsch & Enlow, 1984; Moulton *et al.*, 1990; Ross & Rosser, 1988) indicate that many gay men have incorporated the self-blame label, few have examined the relationship between self-blame (or other HIV attribution theories, for that matter) and psychological functioning. In Moulton *et al.*'s study (1990) among gay men with AIDS and AIDS-related complex (ARC), holding oneself responsible for cause for contracting HIV as well as self-blame was associated with distress among gay men with AIDS, but no such relationship was found among people with ARC. They also compared those who blamed themselves versus those who did not, but no difference in distress was found in either the AIDS or ARC groups.

Several researchers (Farmer & Kleinman, 1989; Kleinman, 1988; Lipowsky, 1970; Schwartzberg, 1992) who have studied the significance of finding specific meaning(s) in (any) illness emphasize the necessity to discern these meanings in order to understand an ill person's coping responses and whether these responses are adaptive or maladaptive. We suggest that the same argument could be applied to explanatory HIV attributions; i.e. the explanatory attributions that individuals develop towards their HIV infection will affect their coping style and psychological responses. To our knowledge no study has addressed this issue, while a growing body of empirical research has explored coping styles and psychological functioning. Empirical data are consistent in that an avoidant coping style does not seem to protect from distress (Antoni *et al.*, 1991; Brieger *et al.*, 1994; Clement, 1992; Kurdek & Siesky, 1990; Leserman, 1992; Namir *et al.*, 1987; Weimer *et al.*, 1991; Wolf *et al.*, 1991), whereas cognitive coping focusing on the positive seems to help promote psychological well-being (Brieger, 1994; Namir *et al.*, 1987; Nicholson & Long, 1990; Wolcott *et al.*, 1986; Wolf *et al.*, 1991).

In this paper our focus is on characteriological self-blame (Janoff-Bulman, 1977) in particular and its association with coping styles and psychological functioning among a group of gay men with HIV. We suggest a two-step-process of explanatory HIV attributions: (1) attributions influence coping styles and (2) attributions influence psychological functioning both directly and indirectly—as a result of the moderating coping process. Within the attributional contextual framework we formulated the following hypotheses:

Hypothesis 1 Attribution is closely related to coping. It is particularly hypothesized that self-blame (an internal) attribution is associated with the avoidant coping style.

Hypothesis 2 Self-blame attribution is positively associated with distress and negatively with psychological wellbeing.

Hypothesis 3 Coping style is associated with psychological functioning. More specifically, avoidant coping style is associated with poor psychological functioning and active self-encouraging coping style is associated with good psychological functioning.

Method

Subjects

The sample consisted of 57 self-defined gay men who were diagnosed with the human immunodeficiency virus (HIV) infection. None of the respondents was diagnosed with AIDS. They were recruited from two sites, 28 of the men were outpatients from two HIV-clinics at the Medical School, University of Heidelberg, Germany and 29 participants were recruited through gay volunteer organizations in Stockholm, Sweden.

The mean age was 38.8 years (range 18–65 years.) Twelve persons were notified about their HIV diagnosis less than six months previously, another four less than one year prior to the study, 15 between one and two years, and 26 more than two years previously (mean 22.6 months). None of the attribution, coping style or psychological functioning variables were correlated with notification time.

Assessment

In-depth interviews of between 1.5 and two hours were carried out. Afterwards the respondents completed a set of questionnaires. The relevant questionnaires considered here are those measuring HIV attribution theories, coping styles and parameters of psychological functioning.

Subjective HIV attribution theories. (Clement, 1992). 20 items were used to assess three relevant subjective HIV attribution theories, namely:

- '*Self-blame*' (the infected person blames himself for being infected; examples: 'It is my own fault that I am infected.'; 'In a way, it is typical of me to get the infection.'); eight items, Cronbach's alpha = 0.81.
- '*External*' (the infected person blames someone else for being infected; examples: 'I absolutely want to know who infected me.'; 'It is other people's fault that I am infected.'); eight items, Cronbach's alpha = 0.83.
- '*Fatalistic*' (the infection is seen as an expression of fate or higher destiny; examples: 'It may be a kind of justice that I am infected.'; 'There might be some meaning in me being infected although I don't understand it.'); four items, Cronbach's alpha = 0.74

Coping style. To assess coping styles, the 80-item-version of the Freiburg Coping List FKV (Muthny, 1986) was used. This questionnaire is based on Lazarus' WCCL (Ways of Coping Check List). The FKV consists of 11 scales of which nine were used for the analyses. They measure:

- '*Avoidance/wishful thinking*' (examples: 'I don't believe it.'; 'I escape into daydreams.'); six items; Cronbach's alpha = 0.86.
- '*Rational problem solving*' (examples: 'I try to understand more about my situation.'; 'I know what I have to do and to try even harder.'); six items; Cronbach's alpha = 0.63.
- '*Religiosity/search for meaning*' (examples: 'My faith gives me support.'; 'I try to see the infection as a challenge.'); six items; Cronbach's alpha = 0.58.
- '*Hedonism*' (examples: 'I allow myself more.'; 'I go out to eat more often.'); five items; Cronbach's alpha = 0.77.
- '*Withdrawal*' (examples: 'I don't want to see anybody.'; 'I keep my feelings to myself.'); five items; Cronbach's alpha = 0.64.
- '*Self-encouragement*' (examples: 'I am prepared to fight.'; 'I try to see the positive sides of my situation.'; six items; Cronbach's alpha = 0.80.
- '*Seeking social support*' (examples: 'I ask other people how they cope with it.'; 'To talk with someone about my feelings.'); five items; Cronbach's alpha = 0.52.
- '*Self-evaluation*' (example: 'I have the resources to cope with the situation.'); seven items; Cronbach's alpha = 0.62.
- '*Downward comparison*' (examples: 'I try to see that others are in a much worse situation.'; 'I say to myself that I cope better with the disease than others.'); three items; Cronbach's alpha = 0.68.

In a second-order factor analysis (Clement, 1992), two orthogonal main factors were identified and interpreted as 'self-encouragement' (27 items; Cronbach's alpha = 0.88) and 'avoidance' (11 items; Cronbach's alpha = 0.91).

Parameters of psychological functioning. *Depressive mood* was assessed by means of a six-item-sub-scale of the FKV ($\alpha = 0.88$). It consists of items describing feelings of resignation and hopelessness (examples: 'Everything seems so hopeless to me.'; 'I am torn down.')

Life satisfaction. The 'Fragebogen zur Lebenszufriedenheit' (Life Satisfaction Questionnaire: Fahrenberg *et al.*, 1986) describes eight areas of life (health, vocational situation, financial situation, leisure, primary relationship, children, sexual life, and perception of oneself). The respondents are asked to mark the degree of satisfaction versus dissatisfaction with each area of life. The internal consistency of the total score is Cronbach's alpha = 0.81.

Results

All respondents made explanatory attributions for their HIV. Out of the 57 respondents, 18 (32%) attributed their HIV infection to self-blame *and* external causes. Only eight persons displayed exclusively external and exclusively self-blame attributions, respectively. Among 23 respondents, no marked external or self-blame attribution could be found. Data indicate that the logically opposing self-blame attribution could be found. Data indicate that the logically opposing self-blame and external attributions co-existed empirically. The fatalistic attribution was slightly associated with external attribution, but independent of self-blame (Table 1).

As hypothesized (hypothesis 1), HIV attribution theories were associated with coping styles (Table 2). Self-blame was significantly correlated with the avoidant coping style, in particular the cognitive aspect of avoidance (avoidance/wishful thinking).

The positive association between external attribution and avoidance/wishful thinking is

Table 1. *Intercorrelations of subjective HIV attribution theories (n = 57)*

	Self-blame	External	Fatalistic
Self-blame		0.47[a]	0.19[c]
External			−0.27[b]

[a] $p < 0.001$, [b] $p < 0.05$, [c] = NS.

Table 2. *Correlations between attribution and coping styles (n = 57)*

	Internal	External	Fatalistic
FKV scales			
Avoidance/ wishful thinking	0.49[a]	0.41[a]	−0.09[d]
Rational problem solving	0.01[d]	−0.09[d]	−0.25[d]
Religiosity/ search for meaning	0.26[d]	−0.03[d]	0.41[a]
Hedonism	−0.06[d]	−0.11[d]	0.16[d]
Withdrawal	0.26[c]	−0.09[d]	−0.13[d]
Self-encouragement	0.13[d]	−0.01[d]	0.13[d]
Seeking social support	0.36[b]	0.16[d]	0.23[d]
Self-appraisal	0.13[d]	−0.01[d]	0.13[d]
Downward comparison	0.15[d]	−0.03[d]	0.15[d]
Second-order factors			
Self-encouragement	0.15[d]	−0.08[d]	0.25[d]
Avoidance	0.47[a]	0.38[b]	0.13[d]

[a] $p < 0.001$, [b] $p < 0.01$, [c] $p < 0.05$, [d] NS.

Table 3. *Correlations between subjective HIV attribution theories and parameters of psychological functioning (n = 57)*

	Internal	External	Fatalistic
Depressive mood	0.60[a]	0.45[b]	0.01[c]
Life satisfaction	−0.52[b]	−0.12[c]	0.12[c]

[a] $p < 0.001$, [b] $p < 0.01$, [c] = NS.

not surprising taking into account the reported intercorrelation of external and self-blame HIV attribution theories.

Fatalistic attribution was clearly related to religiosity/search for meaning. This correlation should, however, not be over-interpreted, since it is almost a circular one: fatalism describes a metaphysical orientation towards fate or higher destiny, which corresponds to the religious tendency to search for a meaning.

Among the three HIV attribution theories, self-blame clearly coincided with depressive mood and life dissatisfaction. As shown in Table 3, the external attribution correlated with

Table 4. *Correlations between psychological functioning and coping styles (n = 57)*

	Depressive mood	General life satisfaction
FKV scales		
Avoidance/ wishful thinking	0.81[a]	0.02[d]
Rational problem solving	−0.10[d]	0.56[a]
Religiosity/ search for meaning	0.02[d]	0.12[d]
Hedonism		
Withdrawal	0.40[a]	0.40[c]
Self-encouragement	−0.34[b]	0.47[c]
Seeking social support	0.42[a]	−0.15[d]
Self-appraisal	−0.07[d]	0.33[d]
Downward comparison	0.07[d]	0.44[c]
Second-order factors		
Self-encouragement	−0.12[d]	0.50[b]
Avoidance	0.40[b]	0.46[b]

[a]$p < 0.001$, [b]$p < 0.01$, [c]$p < 0.05$, [d]NS.

depressive mood, whereas fatalistic attribution was independent of psychological functioning. The clear correlational pattern of the self-blame attribution confirms hypothesis 2.

As hypothesized (hypothesis 3), coping styles differed markedly in their correlational pattern with parameters of psychological functioning (Table 4).

The cognitive and behavioural aspects of avoidance-coping (avoidance/wishful thinking and emotional and social withdrawal) were closely associated with depressive mood. The results also showed a significant correlation between the coping style of seeking social support and depressive mood.

It should be noted that neither the active-cognitive coping style (rational problem solving) nor the second order factor of self-encouraging coping were (negatively) associated with depressive mood.

Life satisfaction was significantly positively related to all active and self-encouraging coping styles (rational problem solving, self-encouragement, self-appraisal, downward comparison, and the second-order factor self-encouragement). As can be seen in Table 4, life satisfaction was negatively correlated with withdrawal and the second-order-factor of avoidance.

Stepwise multiple regression analyses were conducted in order to examine to what extent coping styles could predict each of the parameters of psychological functioning. With regard to depressive mood, coping styles predicted 85% of the variance in contrast to 53% of general life satisfaction (Table 5). Data clearly indicate that avoidance/wishful thinking was by far the most powerful predictor of depressive mood with the variance accounted for by 70%. In contrast, the predictors of life satisfaction explained less variance. Here, rational problem solving accounted for 31% of the predicted variance. Correlational analysis as well as regression analysis confirm hypotheses 3.

Table 5. *Stepwise regression from coping styles to parameters of psychological functioning* ($n = 57$)

	Partial r^2	Model r^2	F	$p(F)$
Depressive mood regressor				
1. Avoidance/wishful thinking	0.70	0.70	57.02	0.001
2. Downward comparison	0.12	0.82	15.73	0.001
3. Seeking social support	0.02	0.84	3.32	0.10
4. Rational problem solving	0.02	0.86	2.45	0.15
Life satisfaction regressor				
1. Rational problem solving	0.31	0.31	11.20	0.01
2. Withdrawal	0.14	0.45	6.00	0.05
3. Avoidance/wishful thinking	0.08	0.53	4.00	0.10

Discussion

From a societal perspective, HIV infection among gay men is still associated with factors of personal responsibility and blame. It is therefore of interest to examine the extent to which gay men have incorporated this view but also the impact of such an attitude on coping and psychological functioning. We found in this study that few of the gay men (eight) had exclusively incorporated attribution of self-blame for their HIV infection. Among 23 of the respondents no marked self-blame or external attribution could be found. It is, however, noteworthy that about one-third of them attributed 'responsibility' to both self-blame and external factors. We would suggest that this co-existence may be understood in terms of ambivalence; on the one hand the individual maintains that he does not 'deserve' the infection and he projects all responsibility into others and on the other hand he attributes the disease to his internal 'preconditions' for contracting the infection.

Our hypothesis that self-blame attribution would be associated with the avoidant coping style was supported. To view one's illness as a reflection/manifestation of one's negative character, psychic readiness and/or bad luck is psychologically painful. Thus it is highly likely that the individual attempts to ward off these cognitions by avoidant manoeuvres, such as those constituting the avoidant coping scale.

No particular HIV attribution theory was tied to good psychological functioning. Moulton *et al.*'s (1990) statement that attributions of personal responsibility for contracting the disease are a cause of distress among people with HIV is strongly supported by our findings; self-blame attribution correlated with depressive mood and a general life dissatisfaction. One way to understand the association could be that self-blame attribution attacks and violates the individual's self-esteem and as a consequence the individual may experience psychological distress. But it can not be ruled out that an already fragile self-esteem may represent a risk factor of developing self-blame attribution and/or there may exist a reciprocal causation.

The model of learned helplessness could be another approach to understand how attributing the cause of HIV to oneself can lead to distress. Non-HIV related research has repeatedly demonstrated that perceived helplessness has a strong positive relationship with depressive symtomatology (Turner & Roszell, 1994). According to the theory, the tendencies to attribute negative events to internal, stable and global factors increases vulnerability to depressive symtomatology. Seligman (1991) stresses that attribution theory (in Seligman's terminology, explanatory style) is 'the great modulator of learned helplessness'. We would

argue that to view one's HIV-seropositivity as a manifestation of one's negative character, etc. implies a sense of lack of control and mastery which may foster feelings of giving up, helplessness and ultimately depressiveness/depression.

It is difficult to determine why those who attributed their HIV infection to external factors reported distress in terms of depressive mood. One partial explanation could be its association with self-blame attribution. Following Bulman and Wortman's (1977) arguments, may/be justice and/or anger concerns were involved. A large proportion of the gay men expressed feelings of injustice ('I really don't deserve to become infected') and thus expressing a sense of being violated of one's beliefs in a just world. Anger appeared to be directed at the person who infected the respondent ('I will definitely find out who infected me' and 'Me being infected makes me furious').

Our hypothesis of a negative correlational pattern between the avoidant coping style and psychological functioning was supported. Consistent with other studies, avoidant coping style was associated with depressive mood, but we also found a relationship between avoidant coping style and general life dissatisfaction.

In conformity with many other studies based on convenient samples, the generalizability of the findings is limited. Consequently they can not be thought of as representative of the entire group of gay men with HIV. In addition, the cross-sectional character of the study makes it impossible to establish causal relationships between HIV attribution theories, coping and psychological functioning.

To conclude, findings presented in this paper clearly illustrate the respondents' need to search for an explanation of their HIV infection. Their ultimate goal is to restore a more or less shattered assumptive world and to regain psychological wellbeing. But as the findings suggest, not all search-for-explanation paths are necessarily constructive but rather induce psychological distress. Self-blame attribution for contracting HIV is related to depressiveness and life dissatisfaction. This association is likely to be even more salient a problem in the future because people (and in particular men who have sex with men) are expected to be aware of how to protect themselves from contracting HIV. Thus, those men who are diagnosed today run the risk of being blamed and guilt-burdened to a much higher degree than earlier and consequently of developing psychological distress. It is therefore important that clinicians are sensitive to signs of self-blame attribution among gay men with HIV. The more we are conscious about the complexity of psychosocial factors that have an impact on the individual's HIV adaptation process and psychological functioning, the better we can adapt our therapeutic efforts to the individual's suffering and thus support the person in a way that is most appropriate and constructive to him.

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