THE RELATIONSHIP BETWEEN DEPRESSION AND COPING AMONG
BLACK AND LATINO MEN LIVING WITH HIV/AIDS

A dissertation presented by

Cyril S. Ubiem

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ABSTRACT

African Americans and Latinos bear a disproportionate burden of health problems with respect to HIV/AIDS when compared to the general population. HIV (human immunodeficiency virus) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). This disease has been reported to be highest among the African American and Latino community in the United States. There are research studies on the relationship between HIV and depression as well as a growing interest in the coping patterns of people infected with HIV disease. In this study, African American and Latino men who are HIV-positive were recruited from two HIV agencies. The Concern and Coping with HIV and Beck Depression Inventory were administered to measure levels of coping and depression among the participants. According to the findings from multivariate analysis of Variance (MANOVA), there was no significant difference in the levels of depression or coping among African American and Latino HIV-positive men. Spearman bivariate correlation also indicated a significant relationship between depression and coping among African American and Latino HIV-positive men. There was no significant relationship between mode of HIV transmission and coping or mode of HIV transmission and depression. These results are discussed in terms of their clinical implications, highlighting the implication for policy, research, and practice.
CHAPTER ONE
INTRODUCTION

This chapter presents the background of the problem, HIV/AIDS, in the general population and specifically among Blacks and Latinos. This chapter also presents the theoretical foundation of this study, significance of the study, statement of the problem, research questions, and operational definitions.

Background of the Problem

African Americans and Latinos bear a disproportionate burden of health problems with respect to HIV/AIDS when compared to the general population (U.S. Department of Health and Human Services, 2001). According to the Centers for Disease Control (CDC) (2005) approximately 40,000 persons in the United States become infected with HIV each year. The latest U.S. Centers for Disease Control report (2007) on the U.S. epidemic found that in 2007, African Americans (51%) and Latinos (18%) represented 69% of the estimated number of HIV/AIDS diagnoses in 2007 (CDC, 2009). White people constituted 29% of the estimated number of HIV/AIDS cases diagnosed in 2007. Meanwhile, African Americans and Latino constituted only 26% of the United States population. Mortality rates until age 85 are higher for blacks than for whites. According to the CDC (2009), at the end of 2007, the estimated number of persons living with HIV/AIDS between 2003–2007 in 50 states and the District of Columbia was 455,636 (CDC, 2009). The HIV/AIDS rate of people of color is more than seven times that of whites. In the past decade, death due to HIV/AIDS has increased dramatically in the African American population, and this disease is now one of the top five causes of death for this group (U.S. Department of Health and Human Services, 2001). In the United
States, the HIV/AIDS epidemic is a health crisis for African Americans. Over the last two decades there has been abundant research on depression and coping within the HIV/AIDS population (Folkman & Moskowitz, 2000; Jenkins & Guarnaccia, 2003; Penedo et al., 2001; Simoni & Ng, 2000). An estimated one in three persons with HIV infection may experience depressive symptoms (Orlando et al., 2002).

The lifetime prevalence of depression in HIV-infected patients has been estimated at 22–45% (Penzak, Reddy, & Grimsley, 2000). HIV-infected patients have been observed to have an increased risk of depression when there is a history of substance use, recent medical hospitalization, and homosexual risk behaviors (Fairfield et al., 2001). The increasing relationship between depression and HIV has prompted this author’s desire to look into the relationship between depression and HIV among Blacks and Latinos living with HIV in the U.S. Another factor that is of importance among Blacks and Latinos living with HIV is the way they cope. Coping processes are better understood by looking at how people cope with specific stressors, rather than treating coping as a stable personality trait (Lazarus & Folkman, 1984). A stressor-specific approach is especially useful for studies of coping with health problems. HIV disease-related stressors include not only fatality, specific symptoms, treatments, side effects, and other physical features, but also secondary social concerns, such as lifestyle stigma, impoverishment, and relational implications of getting and passing on the infection. These stressors may prompt appraisal and coping patterns that differ from other conditions. Coping patterns in response to HIV-related stressors may differ from coping required for stressors that are not life threatening.
Purpose of the study

The purpose of this study is to identify the relationship between depression and coping strategies that urban-based Black and Latino HIV-positive men employ in the management of their infection. It is widely accepted that HIV infection is a stressful life event, and individuals with HIV infection are highly vulnerable to stress (Jia, Uphold, & Faan, 2005). Hopefully, this study will complement the existing work related to coping with HIV/AIDS among Blacks and Latinos as well as the general population of Americans with HIV/AIDS.

Statement of the Problem

Although there are high numbers of Blacks and Latinos living with HIV, little is known about the levels of depression and coping with an HIV-positive status among Blacks and Latinos who often contend with poverty, inadequate access to health care, racism, and poor health outcomes in comparison to Whites. This specific information on coping strategies adopted by Black and Latino men living with HIV may help focus intervention strategies designed specifically for HIV-positive men of color. A person infected with HIV is viewed with stigma, unlike a person who has a disease like cancer. Such stigma could impact the resources available to the individual who has HIV (in terms of his/her levels of depression and coping). Being HIV-positive may mean the loss of health, friends, employment, financial independence, physical intimacy, and the support of one’s family members (Friedland, Renwick, & McColl, 1996). An estimated one in three persons with HIV infection also may experience depressive symptoms (Orlando et al., 2002).
Research addressing the specific coping strategies of Blacks and Latinos living with HIV/AIDS is limited. It is anticipated that social support, religion, and family values contribute to coping with HIV/AIDS among people of color. This study highlights and critically evaluates the specific coping strategies that this population uses. This will inform clinicians in adapting their treatment plans to address the special needs of African-American and Latino men living with HIV/AIDS.

**HIV/AIDS in the General Population**

According to the CDC, in 2006, 50% of all adults and adolescents who were diagnosed with HIV/AIDS in the United States were men who have sex with men (MSM), followed by 33% of adults and adolescents infected through heterosexual contact (CDC HIV/AIDS Surveillance Report, 2006). Among men who were diagnosed with HIV/AIDS in 2006, 67% were infected through male-to-male sexual contact. Sixteen percent of the men contracted HIV through heterosexual contact, and 12% were infected through injection drug use. Among all females who were diagnosed with HIV/AIDS in 2006, 80% were infected through heterosexual contact, while 19% were infected through injection drug use. With regards to gender, 73% of all adults and adolescents who were diagnosed with HIV/AIDS were male, while 26% were female adolescents and adults (CDC HIV/AIDS Surveillance Report, 2006). From 2001 through 2005, the estimated number of persons in the United States living with AIDS increased from 331,512 to 425,910—an increase of 28% (CDC, 2005). Table 1 presents the estimated number of Blacks and Latinos living with HIV at the end of 2007.
Table 1:

*Estimated Numbers of Persons Living with AIDS at the end of 2007, By Race/Ethnicity and Transmission Category—50 States and the District of Columbia* (CDC, 2009).

<table>
<thead>
<tr>
<th>Transmission Category</th>
<th>African American / %</th>
<th>Latino / %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male adult or adolescent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male-to-male sexual contact</td>
<td>60,816</td>
<td>46%</td>
</tr>
<tr>
<td>Injection drug use</td>
<td>34,635</td>
<td>26%</td>
</tr>
<tr>
<td>Male-to-male sexual contact and injection drug use</td>
<td>10,606</td>
<td>8%</td>
</tr>
<tr>
<td>High-risk heterosexual contact</td>
<td>24,932</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>1,002</td>
<td>1%</td>
</tr>
<tr>
<td>Subtotal</td>
<td>131,992</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Female adult or adolescent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection drug use</td>
<td>19,634</td>
<td>30%</td>
</tr>
<tr>
<td>High-risk heterosexual contact</td>
<td>43,811</td>
<td>68%</td>
</tr>
<tr>
<td>Other</td>
<td>1,170</td>
<td>2%</td>
</tr>
<tr>
<td>Subtotal</td>
<td>64,615</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Child (&lt;13 yrs at diagnosis)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal</td>
<td>2,421</td>
<td>96%</td>
</tr>
<tr>
<td>Other</td>
<td>95</td>
<td>4%</td>
</tr>
<tr>
<td>Subtotal</td>
<td>2,517</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>199,124</td>
<td>100%</td>
</tr>
</tbody>
</table>


*Note*: Other includes hemophilia, blood transfusion, perinatal exposure, and risk factors not reported or identified.

During the mid-to-late 1990s, advances in treatment slowed the progression of HIV infection to AIDS and led to dramatic decreases in deaths among persons with AIDS. The decrease in the estimated number of deaths of persons with AIDS continued, but the number of AIDS cases diagnosed during that same period increased. The reasons for the increase in the number of AIDS diagnoses are unclear, but may be due to increased emphasis on testing, and more people living with HIV and thus experiencing the development of AIDS (CDC, 2005). Better treatment has meant greater life expectancy, and thus, a greater number of persons in the United States who are living with AIDS.

**HIV/AIDS among African Americans**

The burden of HIV/AIDS is huge within the African-American and Latino populations. Understanding the positive and negative elements of the coping strategies of these populations is vital in helping those living with HIV/AIDS learn and utilize more effective coping strategies. The statistics on HIV and AIDS in the United States clearly show that all races are affected; however, ethnic minorities tend to make up a disproportionate number of cases in most states. African Americans are particularly affected by the virus, and relatively high rates of HIV can be found in virtually every sector of this community. African Americans constitute 13%, or about 36 million, of the United States population. Fifty-three percent of all Blacks live in the South, with 37% residing in the northeast and Midwest, mostly in large metropolitan areas. About 10% of all Blacks live in the West (U.S. Census Bureau, 2001). African Americans comprised
19,206 (50%) of the estimated 38,730 new HIV/AIDS diagnoses in the United States in the 33 states with long-term, confidential name-based HIV reporting (CDC, 2006). During 2001–2004, the rate of HIV/AIDS diagnoses for African Americans decreased, although the rate for African Americans was still the highest rate for all racial and ethnic groups (CDC, 2005). According to the CDC (2007), the most common methods of HIV transmission for Black men were (1) “sexual contact with other men,” (2) “injection drug use,” and (3) “high-risk heterosexual contact with a person known to have a or to be at risk of HIV infection” (CDC, 2009: 1-63).

In a critical literature review of five online databases, Medline, PsycInfo, Eric, AIDSLine, and SocioFile, for articles published between 1974 and 2005 conducted by Millet et al. (2006), the authors reported that the prevalence and incidence rates of HIV are significantly higher for Black men who have sex with men (MSM) than for other racial groups. Their findings indicated that Black MSM were more likely to report having had a sexually transmitted disease (STD) in the past or to have a current diagnosis of STD. Secondly, Black MSM were less likely than other MSM to know their HIV status and to be tested for HIV early in the progression of their disease. These two factors make Black MSM more susceptible to acquire and transmit HIV than other racial groups. The underutilization of mental health services could explain the late report of HIV diagnosis among Black men. This low utilization has been associated with the mistrust of mental health workers by Black men and women.

Among Black women the primary mode of HIV transmission was heterosexual contact with a man who has HIV, followed by sharing injection drug works (like needles or syringes) with someone who has HIV (CDC, 2006). In 2005, 145 children were
reported to be born to mothers who were infected with HIV. African-American children constituted 73% of the perinatal infections nationwide (CDC, 2005). The estimated number of people under the age of 25 who were diagnosed with HIV from 2001-2004 in the 33 states with HIV reporting were estimated to be 18,849 people. African Americans constituted 61% of the people under 25 years who were diagnosed with HIV. From 2001-2004, an estimated 80,187 African Americans were diagnosed with HIV in the 33 states with HIV reporting. Among the population, 62% were males, and 38% were females (CDC, 2006). In 2003, HIV/AIDS was among the top three causes of death for African-American men aged 25-54 years and among the top four causes of death for African-American women aged 25-54 years. It was the number one cause of death for African-American women aged 25-34 years (CDC HIV/AIDS Reporting System, 2005).

African Americans with HIV often face difficult socioeconomic, cultural, and psychological constraints that may compromise their adjustment. Not only do African-American men with HIV contend with stigma associated with their illness, but they also face exposure to racial discrimination, higher rates of unemployment, and differential access to care (Brown & Sankar, 1998). Poverty has also lead to some HIV-positive men to engage in the sex trade to make a living. Washington and Meyer-Adams (2009) examined HIV prevention programs from the perspective of injection drug-using men who have sex with both men and women involved in the sex trade. They conducted exploratory focus groups of 105 men between the ages of 18 and 40 years who were: African Americans, injection drug users, men who had sex with men and women, and men who frequented parks and other areas for sex trade in Baltimore and surrounding areas. Their findings indicated that there needs to be HIV prevention programs that
include a safe space for injection drug users who have sex with both men and women involved in the sex trade. They also recommended that there needs to be a comprehensive service that includes treatment for substance abuse, job assistance, and methods for improving HIV prevention, such as communication skills to increase condom use during sex for this population.

HIV/AIDS among Latinos

Latinos in the United States continue to be affected by the HIV/AIDS epidemic, accounting for both a greater proportion of AIDS cases than their representation in the U.S. population overall, and the second highest AIDS case rate in the nation, by race/ethnicity (CDC, 2006). The epidemic has had a disproportionate impact on Latinos and young adults, but the impact of HIV/AIDS among Latinos varies across the country and by place of birth. Moreover, studies have shown that Latinos with HIV/AIDS may face additional barriers to accessing care than their White counterparts. According to the CDC (2009), behavioral risk factors for Latinos differ by country of birth. The report states that Latinos born in Puerto Rico are more likely than other Latinos to contract HIV as a result of injection drug use or high-risk heterosexual contact. In contrast, sexual contact with other men is the primary cause of HIV infection among Latino men born in Central or South America, Cuba, Mexico, or the United States. The number of deaths among Latinos with AIDS remained stable between 2001 and 2005, while both Blacks and Whites experienced slight decreases. As the Latino population is the largest and fastest growing ethnic minority group in the U.S., addressing the impact of HIV/AIDS in the Latino community takes on increased importance in efforts to improve the nation’s health. In 2006, HIV was the fourth leading cause of death for Latinos aged 35-44. In
Depression and Coping with HIV

2007, Latinos comprised 18% of the new HIV/AIDS diagnoses in the 34 states with long-term, confidential name based HIV reporting (CDC, 2007). In 2006, Latino children accounted for 19% of children under the age of 13 who were diagnosed with HIV/AIDS. The most common mode of HIV transmission for Latino men was sexual contact with males, followed by injection drug use and high risk heterosexual contact. For Latino women living with HIV/AIDS, the most common mode of transmission was high-risk heterosexual contacts and injection drug use (CDC, 2007). The study by Diaz et al. (1998), specifically with gay/bisexual men, found that Latinos in the United States have the highest rates of unprotected anal intercourse of any racial or ethnic group. According to the CDC (2009), socioeconomic factors such as poverty, migration patterns, social structures, and language barriers add to Latinos’ infection problems. The CDC identified other problems like unemployment, transience, a lack of formal education, immigration status, inadequate health insurance, and limited access to high-quality health care as a hindrance to HIV/AIDS prevention care for Latinos.

HIV and Depression

According to Orlando et al. (2002), an estimated one in three persons with HIV infection may experience depressive symptoms. Depression has also been linked with poor adherence to antiretroviral therapy (Catz et al. 2000). According to Yi, et al. (2006), HIV positive individuals have been indicated to report significant levels of depressive symptoms. Poor spiritual well-being has also been linked to increased risk for depression and other mood disorders in patients with HIV (Yi, et al., 2006). However, there is evidence that with the advent of highly active antiretroviral therapy (HAART), there may be a decrease in mood disorders among HIV-positive individuals (Rabkin, Ferrando, Lin,
Sewell, & McElhiney, 2000). Low-Beer et al. (2000) also stated that as many as one-half of HIV-infected persons report significant levels of depression, therefore making depression a particularly important factor in the mental health of an HIV-infected person. The relationship between depression and HIV prompted the investigation specifically within the African American and Latino populations in this study. The lifetime prevalence of depression in HIV-infected patients has been estimated at 22–45% (Penzak, Reddy, & Grimsley, 2000). HIV-infected patients have been observed to have an increased risk of depression when there is a history of substance use, recent medical hospitalization, and homosexual risk behaviors (Fairfield et al., 2001). Physical limitations resulting from the HIV disease process have been associated with depression and have predicted the incidence of depression in HIV-infected men (Griffin, Rabkin, Remien, & Williams, 1998). Research has found a high prevalence of depression among HIV-infected homosexual and bisexual men without AIDS (Belkin et al., 1992; Burack et al., 1993). HIV-related symptoms, low social support, and unemployment were associated with depression.

Another population at a potentially heightened risk for depressive symptoms is African-American single mothers. African-American single mothers are potentially at heightened risk for depressive symptoms due to chronic social and financial stress associated with minority status, mother-only parenting, and delays in diagnosis and treatment (Barbee, 1992; Warren, 1994). Relative to Latin-American and European-American women, African-American women report more depressive symptoms, although some evidence suggests that the differences are no longer statistically significant when income is statistically controlled (Tompkins et al., 1999). Research by both Biggar and
Forehand (1998) and Tompkins et al. (1999) suggests that HIV-infected African-American single mothers reported more symptoms of depression on a self-report measure than demographically matched non-infected mothers. Jones, Beach, and Forehand (2001) conducted a study to assess the risk for depressive symptoms among HIV-infected African-American single mothers, relative to demographically matched non-infected single mothers using both self-report and clinician-rated scales of depression. Findings from the study revealed that HIV-infected single mothers were rated as having significantly more symptoms of depression than non-infected mothers.

Dalmida (2006) reviewed literature on the relationship between depression and HIV-positive women. The study indicated that women with HIV have substantial higher rates of depression than HIV-positive men. The study also indicated that among HIV-positive women, spirituality is an important buffer against HIV-associated stressors. The report advocated the incorporation of spirituality into mental health care. In clinical practice, getting a history of the patient’s spiritual practice would be important. This spiritual practice information will guide the clinician in making appropriate treatment plans that would either include spirituality or not in the treatment. The specific spiritual practice highlighted by the patient can be addressed in therapy and he/she can be assisted in identifying ways to enhance its use. A critical component of this article was its review of the current literature that highlights the relationship between spirituality and levels of depression among HIV-positive women. The focus on only HIV-positive women is one of the limitations of this study. However, it is believed that the effects of spirituality on the levels of depression can also be applicable to men.
Depression has far reaching consequences with regards to morbidity and mortality in HIV-positive women. Chronic and intermittent depressive symptoms in HIV-positive women are associated with disease progression and higher baseline viral load levels. In general, women with chronic depression have mortality rates twice as high as those with little or no depressive symptoms, and depressive symptoms are more severe among women in the terminal phase of their illness (Cook et al., 2004; Ickovics et al., 2001).

A dominant model in the field explaining the relationships among stress, social support, coping, and depression suggests that an individual experiences stress when stressors and daily challenges exceed his/her resources. Such stress may cause serious emotional distress, including depression (Aneshensel, 1999). However, social support and coping can either buffer or eliminate the effect of stress and, thus, decrease depressive symptomatology. Peterson and colleagues (Peterson, Folkman, & Bakeman, 1996) used the stress and coping theory of Lazarus and Folkman (1984) to explain depressed mood in a sample of African-American gay, bisexual, and heterosexual men and found that psychosocial resources moderated the effects of stressors, hassles, and life events on depressive mood. The groups most severely affected by this comorbidity are minorities (Latinos and African Americans).

In the United States, women experience a greater incidence of depression than men. However, more than six million men (7%) in the United States experience depressive illness in any given one-year period (NIMH, 2003). Men have been reported to cope with depressive symptoms by increasing the intensity of their engagement in work-related activities or engagement in reckless and risky behaviors (Cochran & Rabinowitz, 2000). Men with behaviors that place them at risk for HIV exposure (e.g.,
unprotected sex, intravenous drug use) who experience depressive symptoms may, as a coping mechanism, paradoxically engage in risky behaviors associated with HIV infection. These risky behaviors may expose men to premature mortality (Porche & Willis, 2006).

There appears to be a significant overlap between the symptoms of depression and pain in HIV-infected gay men, with pain being associated with the cognitive symptoms of depression (Evans et al., 1998). Among homosexual men, adaptive methods were related to less depression and higher levels of self-esteem. This is consistent with the study by Brook et al. (1997) which found more adaptive strategies of coping that are associated with less psychological disturbance among several types of patients.

The occurrence of depressive symptoms in an HIV-infected man may be the result of depression not related to HIV infection, depression related to HIV infection, specific opportunistic or other HIV-related disorders, or symptoms such as fatigue or medication side effects (Ferrando et al., 1998). HIV-infected men with HIV-related symptoms who had low social support, were unemployed were more or likely to be depressed (Katz et al., 1996). As stated previously, men with behaviors that place them at risk for HIV exposure (e.g., unprotected sex, intravenous drug use) who experience depressive symptoms may increase their likelihood of engaging in risky behaviors associated with HIV infection (Baillargeon et al., 2003; Hutton, Lyketsos, Zenilman, Thompson, & Erbelding, 2004). An estimated one in three persons with HIV infection also may experience depressive symptoms (Orlando et al., 2002). HIV-infected depressed patients at a sexually transmitted disease (STD) clinic were more likely to have sex for money or drugs, have sex with an intravenous drug user, have sex when high on alcohol or drugs,
have a greater number of lifetime sex partners, and to abuse alcohol or drugs than non-depressed patients (Hutton et al., 2004). In addition to sexual risk behaviors, greater severity of depression was associated with the frequency of injection risk behaviors among depressed injection drug users (Stein, Solomon, Herman, Anderson, & Miller, 2003).

According to Cockram, Judd, Mijch, and Norman (1999), the Hamilton Depression Rating Scale, Montgomery Asberg Depression Rating Scale, Beck Depression Inventory, and the Center for Epidemiological Studies Depression Rating Scale were capable of differentially diagnosing depression in men who were depressed and non-depressed. Porche and Willis (2006) therefore concluded that these tools are capable of assisting clinicians with the diagnostic differentiation of depression among HIV-infected men. Based on this, the Beck Depression inventory was used in the differentiation of depression among participants in this study.

Significance and Benefit of the Study

This study will contribute to the knowledge that is needed in helping people (especially Blacks and Latinos) infected with HIV in coping with their infection and depression. A variety of coping strategies are employed by HIV-infected individuals, and this study seeks to document these strategies. This dissertation aims at highlighting how the sample populations in this study cope with their HIV infection and depression.

HIV-specific information can help health care providers understand HIV concerns and coping, better anticipate felt needs of the newly diagnosed, and shape interventions to assist adaptation (Jenkins & Guarnaccia, 2003). Lazarus and Folkman (1984) proposed that the relationship between stressors and psychological distress is mediated by a
person’s coping responses. On the one hand, active, problem-focused coping is associated with better mood and adjustment (Folkman et al., 1993; Friedland et al., 1996). On the other hand, meaning-based, emotion-focused coping, such as positive reappraisal and positive thinking, is associated with less distress (Pakenham et al., 1994).

Social Support

When people encounter crisis in their lives, they reach out to their support system for help in coping with the stress. The social supports of different individuals vary according to the resources available to them. Social support can be defined as practical, emotional, or informational help that people receive from friends, family, partners, and organizations (Schwarzer, Dunkel-Schetter, & Kemeny, 1994). The type and levels of social support a person receives will go a long way in how the individual will cope with the stress (Jia et al., 2005). Low perceived social support has been shown to be a significant predictor of emotional distress among HIV-positive persons (Kelly et al., 1993). Providers of social support generally include the patients’ family members, friends, and others (Serovich & Brucker, 2000).

Some investigators found that individuals who contracted HIV via homosexual sex or injection drug use (IDU) were less likely to receive support from their family members than friends (Johnston, Stall, & Smith, 1995). Ashton et al. (2005) examined social support and maladaptive coping as predictors of HIV-related health symptoms and their findings indicated that participant’s use of venting as a strategy for coping with HIV stress predicted greater increase in HIV-related physical health symptoms during the next year. The study also revealed that when satisfaction with social support was substantial, this overshadowed venting as a significant predictor of change over the next year in the
number of HIV-related physical health symptoms, with more satisfaction predicting greater decline in the number of physical health symptoms.

Theoretical Formulation

Lazarus (1993) defined coping “as ongoing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p. 237). The ability to cope successfully with a chronic illness such as HIV is influenced by a number of social and psychological factors. Stress and coping theory (Lazarus & Folkman, 1984) provides the theoretical foundation for studying these factors and for intervention. Lazarus and Folkman’s theory emphasizes the individual’s cognitive appraisal of a stressful situation in which he or she appraises a situation as being personally significant and exceeding his or her practical or emotional resources. The use of active behavioral coping strategies has been associated with less mood disturbance in HIV-infected patients (Namir, Wolcott, & Fawzy, 1987; Wolf et al., 1991, as cited in Ashton et al., 2005). A study by Jenkins and Guarnaccia (2003) modified “The Ways of Coping Scale” developed by Folkman & Lazarus (1986) to the specific population of people living with HIV/AIDS.

During the past decade, the author worked with HIV/AIDS patients in Africa in different levels of care and became interested in how these groups of people managed and coped on a daily basis with their illness. Experiences in Africa and in the United States indicate the existence of stigma associated with being diagnosed with HIV. Irrespective of the mode of transmission, the patient is perceived as being irresponsible. The author wants to be able to contribute to the study of depression and coping among HIV-positive patients through this study. Everyone infected with HIV has his or her own way of coping
with the infection. While some coping strategies are helpful, others are less helpful. It is important to identify some of these positive coping strategies for the benefit of others. The ability to cope successfully with a chronic illness such as HIV is influenced by a number of social and psychological factors (Chesney et al., 2003). The Concern and Coping with HIV Scale (Jenkins & Guarnaccia, 2003) that was developed from the Ways of Coping Scale (Folkman & Lazarus, 1980) provided a measure of coping, while the Beck Depression Inventory (1961) provided a measure of depression for persons with HIV.

An attempt is made in this study to investigate the levels of depression among Blacks and Latinos in the United States and how these populations cope with HIV infection. As previously reported, poor spiritual well-being was linked with increased risk for depression (Yi et al., 2006). It is anticipated that HIV positive individuals who are depressed will cope differently, thereby creating a relationship between depression, and coping among African American and Latino men living with HIV/AIDS in this study. It has also been reported by Johnston, Stall, and Smith (1995) that individuals who contracted HIV via homosexual sex or injection drug use (IDU) were less likely to receive support from their family members than friends. Based on this report, it is assumed that mode of HIV transmission will have an effect on coping and levels of depression among individuals living with HIV/AIDS. Based on the information that has been presented thus far, the following research questions were generated.

Research Questions

1. Is there a difference in the levels of depression among Black and Latino HIV-positive men?
2. Is there a difference in the levels of coping among Black and Latino HIV-positive men?

3. Is there a relationship between depression and coping among Black and Latino HIV-positive men?

4. Is there a relationship between mode of HIV transmission and coping among Black and Latino HIV-positive men?

5. Is there a relationship between mode of HIV transmission and depression among Black and Latino HIV-positive men?

Definition of Terms

Coping: Coping is a complex process that involves changing cognitive and behavioral responses to manage specific demands that are appraised as stressful (Lazarus & Folkman, 1984).

Depression: Depression is a brain disorder with a multi-causal etiology. Depression results from a combination of genetic, cognitive, and environmental factors (Atkinson & Grant, 1994; National Institute of Mental Health, 2003).

Coping Strategy: Coping strategy can be defined as a technique for dealing with internal or external stressors that are viewed by the individual as being greater than his or her usual capabilities to handle. Coping strategies are believed to vary in helping the individual adapt effectively (Brook et al., 1997).

Emotion-focused coping: Emotion-focused coping (thoughts and behaviors a person uses to regulate distress) (Lazarus & Folkman, 1984).

Problem-focused coping: Problem-focused coping (managing the problem causing distress) (Lazarus & Folkman, 1984).
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HIV: HIV (human immunodeficiency virus) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). This virus may be passed from one person to another when infected blood, semen, or vaginal secretions come in contact with an uninfected person's broken skin or mucous membranes. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breast-feeding. People with HIV have what is called HIV infection. Some of these people will develop AIDS as a result of their HIV infection (CDC, 2006).

Chapter Summary

In summary, this section has highlighted the high rate of HIV infection within the African American and Latino populations. This chapter presents the background of the problem as it relates to HIV/AIDS in the United States. It also discussed the purpose of the study and statement of the major variables. Depression among different populations and its relationship to HIV/AIDS was highlighted. Some studies report high levels of depression among HIV-positive individuals while some reports indicate lower levels of depression. The significance of the study and the role of social support in coping with HIV were also reported. The theoretical formulation based on the coping theory of Lazarus and Folkman was presented. Finally, the research questions that guided the research findings were reported.
CHAPTER TWO

REVIEW OF THE LITERATURE

In this chapter, a review of the literature related to HIV/AIDS and coping will be presented. The relationship between the cultural values of African Americans and Latinos as they relate to coping with HIV will also be examined. It is also important to understand the mental health concerns and needs of this population, levels of depression, and the value of religion in coping. The Concern and Coping with HIV scale (Jenkins & Guarnaccia, 2003) was used in the assessment of coping among the sample population. Finally, research on the relationship between depression and HIV, and specific coping strategies were critically reviewed.

The Cultural Values of African American and Latino Populations

It is important to examine the cultural values and the unique experiences of Latinos and African Americans to understand their mental health needs. These cultural values that various communities share have a great significance in shaping how individuals cope with personal problems. Some of these problems can be viewed as family or individual problems. For example, collectivist cultures tend to help each other, and family values are stressed over personal gains. Those who bring shame upon their families are often excluded or abandoned. HIV/AIDS has been a highly stigmatized disease which can lead to such exclusions. Latino families are structured in ways that often value personal honor, often in deference to elders and males (Robinson, 2009). In Latino culture, a premium is placed on personal relationships. Personalismo, or a desire to be close, to know one another intimately, and to communicate personally rather than impersonally, represents a value orientation common to many Latinos (Arredondo, 1992;
Gloria & Peregoy, 1995, as cited in Robinson, 2009). Catholicism acts as a strong cultural (or social) anchor for Latinos (Robinson, 2009). Overall, the church and faith play a crucial role and shape core beliefs, such as: (a) the importance of sacrifices; (b) charitability and service to others; and (c) long suffering, even in the face of adversity (Sue & Sue, 1990, cited in Robinson, 2009). Among Latinos the importance of family can be seen in their living arrangements. Although family characteristics vary by Latino subgroups, as a whole, Latinos, like Asian Americans and Pacific Islanders, are most likely to live in family households and least likely to live alone. In addition, children (especially the females) tend to remain in the family until they marry (U.S. Department of Health and Human Services, 2001).

Common values that African Americans in the United States share include valuing the extended family and outside blood relatives. African Americans place emphasis on the collective, with the “self” extending to unite with others (Robinson, 2009). Communication patterns are not limited to verbal dialogue or standard English, as most Black people depend on nonverbal modes of communication patterns.

_Intersection of Culture and HIV/AIDS among African Americans and Latinos_

Latinos have consistently demonstrated lower levels of HIV knowledge compared to other groups (Hingson, Strunin, & Craven, 1989). Barriers to HIV education among Latinos include language and cultural differences, low literacy levels, strong anti-homosexual attitudes, a denial or minimization of risk, and an emphasis on traditional gender roles and differences (Sabogal, Perez-Stable, Otero-Sabogal, & Hiatt, 1995). Latino women who are foreign-born are less likely to use condoms, and are more likely to be embarrassed to ask their partners to use one (Marin & Marin, 1992). Compared to
non-Latino white and African-American women, Latinas have been found less likely to use condoms in the context of casual sexual relationships, although Puerto Rican women specifically have been found less likely to use condoms in relationships of longer duration and greater emotional investment. The relative lack of condom utilization has been attributed to cultural norms (Loue & Sajatovic, 2006). Marin and Marin (1992) reported that Latino men and women were embarrassed to buy condoms. Latinos have been reported to disclose their HIV status to their primary sexual partners and closest friends, with lower disclosure rates to fathers and mothers (Zea, Reisen, Poppen, Echeverry, & Bianchi, 2004).

A number of cultural, socioeconomic, and health-related factors contribute to the HIV epidemic in the Latino community. Research shows that behavioral risk factors for HIV/AIDS differ by country of birth. For example, data suggest that Latinos born in Puerto Rico are more likely than other Latinos to contract HIV as a result of injection drug use. By contrast, sexual contact with other men is the primary cause of HIV infections among men born in Central or South America, Cuba, Mexico, or the United States (CDC, 2009). Although many Latinos are increasingly engaged in the fight against HIV/AIDS, some Latino communities have been slow to join the effort. Some of the reasons are attributed to cultural values such as machismo (sense of manliness). Many Latinos who have sex with men identify themselves as heterosexual, and as a result, may not relate to prevention messages crafted for gay men (CDC, 2000). According to Jarama et al. (2005) Latino men holding strong machismo beliefs are more likely to have multiple partners and unprotected anal sex casually.
The African-American community typically opposes open conversation about being gay and condemns homosexual behavior (Stokes & Peterson, 1998; Wright, 1993), and the gay community may not understand or appreciate oppressions associated with being African American (Peterson et al., 1996). Thus, African-American gay or bisexual men may experience homophobia within the African-American community and racism or prejudice within the gay community. African-American gay men may place less emphasis on disclosing their sexual orientation to others than a White gay man, fearing that he might jeopardize needed support from the African-American community as a racial minority (Kennamer et al., 2000).

There are high numbers of incarcerated young Black and Latino men who engage in unprotected sex. Some of the men are raped while others engage in anal sex voluntarily without a condom. Some incarcerated men engage in sex to make money and buy drugs. There has been research on the relationship between drug use and sex in prisons. Raj and Amaro (2004) have reported that crack use is related to sexual risk in sex trade and prison. They also reported that sexual activity with male partners occurs for African American men who may not otherwise identify themselves as gay or bisexual. Wright (1993) found that some heterosexual-identifying African American men engage in sex with men to satisfy their sexual or economic needs. In a study by Harawa et al. (2006), the authors reported that African American men who have sex with both men and women have the highest rate of incidence and prevalence rate of HIV among ethnic/behavioral risk groups in the United States. They also found that many HIV-positive individuals would rather disclose their HIV status when trying to establish a relationship or when in a steady relationship. It can be understood that individuals will not disclose their HIV
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status because of the stigma associated with HIV-positive diagnosis. However, this lack of disclosure cannot only be limited to African Americans. Latinos have also been reported to disclose their HIV status to only their primary sexual partners and closest friends (Zea, Reisen, Poppen, Echeverry, & Bianchi, 2004). Millet et al. (2005) also reported that Black men who have sex with men and women but do not identify as gay or disclose their bisexual activities to their main female partners are the main reason for the increase in HIV infections in Black women. The stigma associated with being gay in the African-American community has made it difficult for the gay African-American man to be gay without the fear of being ostracized. This fear may be the reason why some African-American men engage in sex with both men and women; they are attempting to hide their sexual orientation.

Amaro and Raj (2004) have made other findings on condom use and reported that women and adolescent girls indicated that they may remain silent about condom use in their relationships due to the stigma attached to asking their partners to use condoms. Such stigma and fear indicates that if a woman asks her partner to use a condom, she is either infected with HIV or does not trust her partner. This decreases the likelihood of women initiating safer sex. The inability of women to advocate for the use of condoms during sex makes prevention of HIV in women more difficult.

The Value of Religion in Coping with HIV/AIDS

Spiritual and religious practices and beliefs are important to some Latino groups. Catholicism has played a major role in the lives of Puerto Ricans in Puerto Rico. Spiritual beliefs and/or religion may be important in coping with mental illness, particularly for Latinos. Latino Americans have been found twice as likely as Non-Latinos to seek church
assistance to address family problems, depression, worry, and fear. Loue and Sajatovic (2006) conducted a qualitative study with 41 female participants to examine the context of HIV risk and risk reduction strategies among severely mentally ill (SMI) Puerto Rican women residents in northeastern Ohio. Participants ranged in age from 19 to 51. Almost three-quarters of the 41 participants were born in Puerto Rico; 51.2% relied on Spanish as their primary language. Slightly over one-half of the women had less than a high school education, 65.9% were unemployed, and 58.5% relied on social security disability as their primary source of income. Almost three-quarters of the women were married or living with a partner and 90.2% had one or more children. About 68.3% of the individuals reported identification with a religious faith. A large proportion of the participants reported that their religious or spiritual beliefs were critical to their coping, had influenced them to reduce risk, and/or provided them with needed social support. Several participants also reported having experienced rejection from their faith communities. The emphasis on spirituality among these study participants is consistent with previous research demonstrating the importance of spirituality in Latino culture and a reliance on spiritual beliefs as a means of coping among the severely mentally ill. Loue and Sajatovic (2006) therefore suggest that including a spirituality/religiosity component in HIV prevention programs and incorporating spiritual beliefs into secular HIV prevention efforts designed for Latinas may be critical to the initiation and maintenance of risk reduction behaviors, e.g., reducing the number of sexual partners and abstaining from drug use.

Prayer and rediscovery of what is important in life tend to be the most prevalent coping responses to HIV, followed by positive coping strategies such as seeking
information or making plans (Simoni & Ng, 2000). The study paid specific attention to
the Latino community and further highlights the importance of religion/spirituality in
coping with HIV/AIDS.

Leserman et al. (1992) found that, among gay men with HIV, African-American
men were more likely than White men to rely on religion and denial to deal with the
threat of AIDS. African-American and Latino youth with HIV reported higher levels of
spiritual hope and passive/avoidant coping responses (Rotheram-Borus et al., 1996).
Studies suggest that African Americans report higher usage of several coping responses,
including positive, passive, and spiritual coping strategies. African Americans have been
reported to use spiritual coping at much higher rates than Whites. This finding has been
noted in another study by Bourjolly (1998). Historically, African Americans have been
considered to be more “religious” than Whites (Loiacano, 1993), and the church is
especially important in African-American communities (Icard, 1985; Stokes & Peterson,
1998).

Spirituality and HIV/AIDS

Studies show that HIV-infected African-American men and women frequently
employ religious activity as a coping response (Kaplan et al., 1997). Cotton et al. (2006)
interviewed 450 HIV/AIDS patients from 4 clinical sites for a period of 12 to 18 months.
The aim was to characterize spirituality among the sample population and also examine
the relationship between spirituality and clinical as well as demographic variables. The
participants were composed of 50% African Americans, 45% Caucasians, 2% Latinos,
and 2% others. Eighty-six percent of the participants were male and 14% were female.
Results were analyzed using multivariable linear regression models. The results indicate
that a majority of the participants endorsed spirituality as an important factor in their lives. The participants indicated some sense of meaning and purpose in their lives and reported deriving comfort from their spiritual beliefs. However, most of them participated in nonorganized religious activities. This study highlights the importance of spirituality in the lives of individuals living with HIV/AIDS. In one of the sites for this study, discussion with one participant focused on the role of religion/spirituality in coping with HIV. He indicated that he was spiritual and uses spirituality as a coping mechanism. However, he stated that he does not go to church because of the stigma he perceived in church about his sexual orientation and HIV-positive status. It is possible that HIV-positive individuals are spiritual and not religious and feel ostracized by their communities of faith. They pray on their own and use spiritual involvement as a coping strategy, but do not attend religious organizations.

Research on religious activity in coping with HIV/AIDS, which has focused on White gay males, indicates that such activity facilitates coping with illness. For example, 90% of one HIV-infected sample who used religious healing perceived it to be helpful (Anderson et al., 1993). In a study by Carrico et al. (2006) on the path model of the effects of spirituality on depressive symptoms and 24-h urinary-free cortisol in HIV-positive persons, the investigators found that spirituality was associated with lower depressive scores. The authors used baseline data from 130 HIV-positive gay men and 134 HIV-positive women that they collected from 1998 to 2004 for their study. Forty-nine percent of the participants were African Americans, 25% were Caucasians, and 13% were Latinos. The investigators used the Beck Depression Inventory to assess the depressive symptoms among their study participants. I agree with the authors that
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Spirituality has a potential to lower the levels of depression among HIV-positive persons as reported in other studies. For example, Simoni and Ortiz (2003), and Woods, Antoni, Ironson, and Kling (1999) observed that spirituality was also associated with lower depressive symptoms among HIV-positive subjects.

Biggar and Forehand (1999) investigated the role of religious activity in the psychosocial adjustment of 205 inner-city African-American women, one-half of whom were HIV infected. Findings indicated that HIV-infected women reported praying more than non-infected women. However, infected women reported that prayer is less important in coping with their illness than the non-infected women reported it would be if they had a different illness. The findings suggest that, when faced with HIV, African-American women do rely on prayer, but compared to non-infected women, may be cautious in terms of their beliefs about the importance of prayer as a coping procedure. However, they do view prayer as important. Spirituality, hope, and optimism may be powerful internal resources that African Americans draw on in times of acute distress. This finding implies that when designing interventions specifically for African Americans with HIV, integrating spirituality may be particularly important (Tate et al., 2006). Having a control sample of non-infected women in the study makes it easy to compare the results. However, limiting the study to only women could also restrict the ability to generalize the findings to the general population of men and women living with HIV.

Social Support and Coping with HIV/AIDS

Support for people living with HIV infection can come from multiple sources, including family, friends, relationship partners, professional care-givers, and others
There are three functionally distinct types of social support: emotional support consists of affection, comforting, and encouragement that results in a sense of belonging and personal worth; informational support increases one’s knowledge base, and instrumental support entails practical assistance with daily living. Research has shown that emotional, informational, and instrumental support can directly alleviate psychological distress associated with chronic illness and can indirectly buffer the effects of stressful life events (Cohen, 1988; Green, 1993).

The role of social support has been fairly consistent across studies. The lack of social support, as well as dissatisfaction with it, has been associated with increased psychological distress in HIV-positive (and -negative) gay men (Friedland et al., 1996). Social support, including belonging to a social network, perceived satisfaction with support, and the frequency of emotional support, information, and tangible assistance are a major buffer in coping with HIV-related stressors. It is also associated with lower depression rates (Hays et al., 1990b, 1993; Metts et al., 1996; Siegel et al., 1997) and a slower progression to an AIDS diagnosis (Leserman et al., 1999, 2000). In studies of social support among gay men with HIV, individuals are more likely to rely on friends and intimate partners providing support (Catania et al., 1992; Hays et al., 1990b). In addition, among men and women with HIV, support from friends and intimate partners are likely to be perceived as more helpful than that of family members (Barbee et al., 1998).

Social support has structural aspects (e.g., number of social contacts); support functions (e.g., tangible/instrumental, emotional); and qualitative aspects (e.g., satisfaction with support), all of which have been related to psychological adjustment.
among gay men with HIV (Fleishman & Fogel, 1994; Hays et al., 1992; Pakenham et al., 1994; Siegel et al., 1997). Among HIV-positive men and women, negative associations were found between perceived support and avoidant coping responses such as isolation, anger, and wishful thinking. The above findings were consistent with the idea that type of coping mediated the relationship between perceived support and mood (Fleishman et al., 2000). African-American gay men were less likely to seek social support, particularly from family members, and were more dissatisfied with their social support networks than White gay men (Leserman et al., 1992; Peterson et al., 1995). Ostrow and colleagues (1991) found, in a sample of HIV-positive gay/bisexual men, that African-American men were less likely to be open about their sexuality with their primary support network than White men, and reported that their support networks were less supportive than those of White men.

Tate et al. (2006) examined the relationship between race and social support in coping with HIV infection in a sample of gay and bisexual men (African American and White). After accounting for the effects of education and grief reaction, African Americans reported using higher levels of multiple coping strategies than White men. In addition, men with high social support reported differences in coping from men with low social support. Specifically, persons with higher levels of social support reported more positive action and sought greater social support. Individuals with low social support reported higher scores on self-destructive behaviors. Consistent with a number of studies (Brantley et al., 2002; Heckman et al., 2000), there appear to be racial differences in coping. As predicted, African-American men reported using higher levels of positive, passive, and spiritual coping. There was a trend in the data suggesting that African-
American men also seek social support at greater levels than White men. One of the disadvantages of this study is that it excluded Latinos even though they are one of the minorities with the heavy burden of HIV/AIDS in the United States. However, this study is among the few that looked at the relationship between race, social support and coping among HIV-positive individuals. The results make it possible to compare coping factors between African Americans and Caucasians.

People who are HIV-positive who do not attend support groups have been reported to have more emotional distress, including depression, than those who do attend. Non-attenders are also more likely to endorse avoidant coping strategies than attenders. Support group non-attenders are therefore characterized as avoidant in their coping styles (Kalichman et al., 1996).

African Americans and Mental Health

The high rate of African Americans with HIV/AIDS poses special challenges related to mental health. HIV infection can lead to mental impairment, from minor cognitive disorder to full-blown dementia, as well as precipitate the onset of mood disorders or psychosis (U.S. Department of Health and Human Services, 2001). African Americans consistently rank as more impoverished than other racial/ethnic groups. Socio-economic status is linked to mental health; poor mental health is more common among those who are impoverished than among those who are more affluent. Studies show that many African Americans do not believe that authorities have their best interests in mind, with historical and contemporary negative treatment of African Americans fostering this mistrust (U.S. Department of Health and Human Services, 2001). Due to the mistrust of authorities, many African Americans seek mental health
care at lower rates than Whites. African-American attitudes toward mental illness are another barrier to seeking mental health care. Mental illness retains considerable stigma, and seeking treatment is not always encouraged (U.S. Department of Health and Human Services, 2001). One study found that the proportion of African Americans who feared mental health treatment was 2.5 times greater than the proportion of Whites (Sussman, Robins, & Earls, 1987). After entering mental health care, African Americans are more likely than whites to terminate treatment prematurely (Sue et al., 1994). Most African-Americans will not seek treatment until it has become an emergency (Hu et al., 1991).

According to Robinson (2009), when compared to the general population, Black people are more likely to be exposed to violence, which increases mental health symptoms such as post-traumatic stress disorder (PTSD) and depression. Access to mental health care is limited. Among Blacks who have health insurance, treatment-seeking behavior for mental health services does not automatically increase. The lack of treatment-seeking behavior is related to stigmatizing attitudes among African Americans regarding mental health care. When considering this lack of treatment-seeking behavior, one must also look at the myriad health problems Blacks encounter, and how those problems relate to the experiences of poverty, substandard housing, underemployment, unemployment, and chronic racial discrimination.

A study by Ramirez-Valles (2002) presented a conceptual framework of the protective effects of community involvement in HIV/AIDS-related groups and organizations for HIV/AIDS sexual risk behavior among gay and bisexual men. Ramirez-Valles’ framework argues that community involvement moderates the association between three socio-structural risk factors: poverty, homophobia, and racism and sexual
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risk behavior. It also states that involvement with the HIV/AIDS community reduces
sexual risk behavior and its effects on four mediating factors: peer norms, self-efficacy,
positive self-identity, and alienation. The framework proposes five socio-cultural barriers
to facilitators of community involvement in HIV/AIDS groups: motives for participation,
poverty, acculturation, stigma, and perceived opportunities. It also addressed burnout as
one potential negative consequence of community involvement in HIV/AIDS-related
organizations and groups. The importance of community involvement has been
highlighted in this study making coping with HIV/AIDS better among HIV-positive
individuals.

Kraft, Beeker, Stokes, and Peterson (2000) conducted a qualitative analysis of
seventy-six, 18-29 year old African-American men who have sex with men (MSM) in
Chicago and Atlanta to identify perceptions of community and components of a
community-level HIV/AIDS intervention. They asked if the participants, or African-
American MSM they knew, felt like they were part of a community. They asked about
the nature of the communities, including the following: “What kinds of people form the
community? How is the community different from others? How is it helpful to you?
What is hard about being in the community? What would help the community be
stronger?” (Kraft, Beeker, Stokes, & Peterson 2000, p. 433). They indicated in their
findings that many men reported feeling marginal within both the African-American and
gay White communities because of perceived homophobia and racism. Some participants
reported feeling part of the gay community because of social structures, and functions,
including social support, and mobility. The authors suggested that divisions among
groups of MSM, lack of settings for nonsexual interaction with other MSM, lack of
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leadership, and negative attitudes toward homosexuality may make it difficult for men to participate in activities to alter community contexts that influence behavior. They recommended that increasing social support and building community should be part of initial community-level interventions. They also suggested that community-building might identify leaders, create new settings, and create opportunities for dialogue between MSM and African-American community groups to address negative perceptions of homosexuality. This qualitative study provides a rich source of information for the gay African American communities in Atlanta and Chicago. The findings could be applied to African American communities in general.

Latinos and Mental Health

According to the U.S. Department of Health and Human Services (2001), the rate of mental health disorders among Hispanic Americans living in the community is similar to that of non-Hispanic White Americans. However, adult Mexican immigrants have lower rates of mental disorders than Mexican Americans born in the United States. Similarly, adult Puerto Ricans who live in Puerto Rico tend to have lower rates of depression than Puerto Ricans living in the United States. Latino youths were also reported to experience more anxiety-related and delinquency problem behaviors, depression, and drug use than non-Hispanic White youth. Latinos’ lack of health insurance is a significant barrier to their obtaining mental health care. Although Latinos comprise 15 percent of the U.S. population, they represent nearly one out of every four uninsured Americans. Nationally, 37 percent of Latinos are uninsured; this is more than double the rate for whites. The available studies consistently indicate that Latino community residents with diagnosable mental disorders are receiving insufficient mental
health care. Among Latino Americans with mental disorders, fewer than one in eleven contact mental health care specialists, while fewer than one in five contact general health care providers. Among Latino American immigrants with mental disorders, fewer than one in twenty use services from mental health specialists, while fewer than one in ten use services from general health care providers (U.S. Department of Health and Human Services, 2001, p. 142). Diaz, Ayala, Bein, Henne, and Marin (2001) assessed the relationship between experiences of social discrimination (homophobia, racism, and financial hardship) and symptoms of psychological distress (anxiety, depression, and suicidal ideation) among self-identified gay and bisexual Latino men in the United States. They collected data from a sample of 912 men (self-identified as both Latino and non-heterosexual) recruited from the venues and public social spaces identified as both Latino and gay in the cities of Miami, Los Angeles, and New York. Results from their study indicated high prevalence rates of psychological symptoms of distress in the population of gay Latino men during the 6 months before the interview, including suicidal ideation (17% prevalence), anxiety (44%), and depressed mood (80%). Their findings also indicated that social discrimination was a strong predictor of psychological symptoms. They concluded that the mental health difficulties that gay and bisexual Latino men in the United States experience are directly related to a social context of oppression that leads to social alienation, low self-esteem, and symptoms of psychological distress.

Ramirez-Valles, Fergus, Reisen, Poppen, and Zea (2005) studied the effects of community involvement among a group of HIV-positive Latino gay men. The study specifically examined the effects of community involvement in AIDS and gay-related organizations (e.g., volunteerism and activism) and experienced homosexual stigma on
three psychological well-being indicators: self-esteem, depression, and loneliness. The research was conducted among a cross-sectional sample of 155 HIV-positive men living in New York and Washington, DC. The result indicated that experienced stigma associated with homosexuality was attributed to psychological well-being. It also states that community involvement seems to compensate the association between stigma, depression, and loneliness, while buffering the association with reduced self-esteem. This type of active involvement in the HIV community has been described as problem-focused coping by Lazarus and Folkman (1984) and recognized as an effective coping mechanism. It has also been linked with lower levels of depression as confirmed by the study mentioned above. Therefore, encouraging HIV positive individuals to actively participate in the community is recommended.

Coping Theory

Coping is not considered a style or personality trait that remains stable across a variety of situations; rather, it is a set of strategies that are available to be implemented to match specific situations. The emergence of HIV/AIDS has created different stressors and the need for different coping strategies. HIV/AIDS not only causes stress, it also has other psychosocial problems associated with it. Despite the abundant research in the field of stress and coping, not enough specific research has been applied to the understanding and application of relevant coping strategies that African Americans and Latinos utilize in coping with their HIV infection. Stress and coping theory (Lazarus & Folkman, 1984) posits that appraisal and coping processes have a significant role in the maintenance of well-being under conditions of stress. According to Lazarus and Folkman’s theory, the coping process begins with an appraisal, defined as the individual’s evaluation of the
personal significance of a given event and his or her perception of the adequacy and availability of coping resources. A threat, harm, or challenge appraisal then prompts coping. Coping is either emotion-focused (thoughts and behaviors a person uses to regulate distress) or problem-focused (managing the problem causing distress). Appraisal and coping both generate emotion throughout the coping process. The coping process is dynamic, with appraisal, coping, and emotion influencing each other as the coping process progresses and as the situation unfolds and changes.

A basic tenet of stress and coping theory is that the coping process needs to be assessed within the context of the stressful situation (Lazarus & Folkman, 1984). According to the theory, it is more useful to ask what people do to cope with a particular stressful event rather than to ask what they do to cope in general, because both the responses used and the effectiveness of those responses depend on characteristics of the situation. However, this does not mean that there are no consistencies in an individual’s approach to particular classes of stressors. Looking within individuals and across illness-related stressful events, there may be evidence of both stability and variability in appraisal and coping. Stability in these processes is associated with personal characteristics or with stable features of the stressful events the individual experiences. Variability in appraisal and coping is associated with situational demands and constraints, including the extent to which the situation is changeable or controllable, resources available for coping, and other goals and demands that may compete for time and resources.

The stress and coping perspective focuses on the way in which personal meaning gives rise to particular appraisals and informs the individual’s understanding of
possibilities for coping in response to a given stressful event. If the stressor is appraised as controllable, the individual may be more likely to use problem-focused, and less likely to use emotion-focused, coping strategies than if the event is appraised as an uncontrollable situation.

A number of typologies have been proposed to identify the salient dimensions of coping behavior and determine their relationship to emotional adjustment. One such schema, proposed by Folkman and her colleagues, involves detachment- or avoidance-focused coping versus involvement- or action-focused coping. Folkman et al. (1993) found that detachment coping (consisting of such behaviors as keeping feelings inside, denying the problem, etc.) was related to increased depressed mood among (mostly White) gay men with and without HIV.

In a longitudinal study by Zakowski, Hall, Klein, and Baum (2001) on the “goodness of fit hypothesis” relevant to coping, the authors sought to clarify the associations among control, appraisal, coping, and stress within this theoretical framework. Findings indicated that events that were appraised as relatively uncontrollable were addressed with less problem-focused and more emotion-focused coping efforts, and vice versa. These data suggest that when people are confronted with a stressor they consider to be relatively uncontrollable, they are more likely to use coping strategies that regulate their emotions rather than engage in what may seem to be futile efforts at changing the situation. Although this study was not conducted among HIV-positive individuals, it provided information on when individuals use problem-focused coping as opposed to emotion-focused coping. The result may have a limitation with regards to its application to individuals living with HIV since the stress associated with
living with HIV may be different from ordinary stress. Therefore, the findings may not completely apply to individuals living with HIV because the study was not conducted with individuals living with HIV/AIDS.

**Social and Psychological Factors that Influence Coping with HIV**

There are cultural and psychological factors associated with the way people cope with their HIV infection. In a longitudinal study conducted by Moskowitz and Wrubel (2005) on coping with HIV as a chronic illness, they noticed that there were cultural influences on the way that participants appraised being HIV-positive. For example, it is a common American cultural value to be oriented toward future outcome. However, when a person is infected with a disease that could curtail their future existence, looking to the future can become a continually traumatic awareness of loss that becomes depressing. Personal dispositions, individual events, and cultural meanings likely combine to shape how the person appraises and responds to the experience of having HIV. The HIV experience does not depend solely on events that impinge upon the person or on the person’s predisposed ways of acting, but is a transactional process that unfolds over time that involves the cultural meanings available to a person and the resources and understanding the person brings to the event, as well as the events themselves.

Zea, Reisen, Poppen, Bianchi, and Echeverry (2005) conducted research with a sample of 301 Latino gay and bisexual men from clinics, hospitals, and community agencies in New York City. The study measured the level of disclosure of HIV-positive serostatus to members of their social networks and the mental health consequences of such disclosure. Multivariate regression was used in predicting the three outcomes concerning disclosure of HIV-positive status: the extent to which participants had
revealed their serostatus to casual partners, to close friends, and to family members. Results indicated that disclosure was related to greater quality of social support, greater self-esteem, and lower levels of depression. Their research also demonstrated that, generally, Latino gay men are selective in choosing people to whom they disclose their serostatus and that disclosure tends to be associated with positive outcomes. As noted by the authors, one limitation is that the time of disclosure was not disclosed. The study did not take into account the potential difference in disclosing HIV-positive status after a year of infection, for example, or 10 years of infection. Limiting the study to Latinos only might make it difficult to generalize the findings to other ethnic groups.

Evidence also shows that race is associated with the stage of HIV infection at the time of initial treatment. Blacks and Latinos tend to wait longer to seek treatment than Whites, which can impact disease progression and survival rates (Easterbrook et al., 1991). Domanico and Crawford (2000) found that Latino men reported a significantly greater number of physical symptoms than African-American men, indicating a higher degree of debilitation and further progression of HIV infection in this population. The reasons for delayed treatment-seeking behavior among ethnic minority groups may be due to limited access to health care resources and education, logistical difficulties (e.g., transportation, financial, or time constraints), or cultural and social barriers (e.g., racial, class, or linguistic differences). These impeding factors could also have an impact on the ability of HIV-positive Latino gay men to actively care for their health.

Evidence from the literature supports the argument that coping strategies can be influenced by sociocultural factors such as racial or ethnic background. Leserman, Perkins, and Evans (1992) studied a group of 52 asymptomatic HIV-positive homosexual
men and 53 HIV-negative homosexual men used for descriptive comparison. Their study aimed to: (1) describe the coping strategies used by asymptomatic HIV-positive homosexual men, (2) examine the relationship of coping to dysphoria and self-esteem, and (3) explore how race and social support correlate with coping. They achieved this by using data on coping, social support, dysphoria, and self-esteem from self-report measures, and they also used the Hamilton Rating scale for depression. They found that their participants primarily coped with the threat of AIDS by adopting a fighting spirit, reframing stress to maximize personal growth, planning a course of action, and seeking social support. African Americans were found to express more denial, more helplessness, and less social support. The results also indicated that African American were more likely than Whites to endorse the coping strategies of helplessness and denial when dealing with their HIV. The mental health issues of African Americans and Latinos will be further elaborated in the section on the mental health of African Americans and Latinos.

Types of Coping Strategies

The major coping categories have been dichotomized into problem-focused and emotion-focused. However, various other strategies such as adaptive coping, maladaptive coping, active and avoidant coping styles exist and are utilized by different groups. Some of these effective coping strategies will also be highlighted in upcoming sections. Here, though, focus is on emotion- and problem-focused coping. Emotion-focused coping strategies are directed toward altering the individual’s emotional response to the stressor and include strategies such as self-blame, wishful thinking, and avoidance. They are focused on internal emotional states, not on the situation that triggered the emotional states. Problem-focused coping, by contrast, functions to alter the problem itself by
directly acting on the situation. Some coping strategies, such as seeking social support, may serve both functions simultaneously (Vitaliano, Maiuro, Russo, & Becker, 1987).

In a study by Penedo et al. (2001) the authors sought to evaluate the relationship between dysfunctional thought patterns (i.e., negative attitudes) and depressive symptoms, as well as the possible role of coping strategies as mediators of the relationship between dysfunctional attitudes and psychological distress among HIV-positive men having sex with men (MSM). The study sampled 115 HIV-positive, symptomatic MSM. They found that higher levels of dysfunctional attitudes were consistently associated with more reported depressive symptoms. They also found that the use of adaptive coping strategies, such as active coping, was associated with lower depression, whereas denial was associated with higher levels of depression. The importance of adaptive/active coping strategies has been linked with lower levels of depression in a study by Namir, Wolcott, Fawzy, and Alumbaugh (1990).

People usually use both problem-focused and emotion-focused coping, although one type may be emphasized depending on the context, appraisal of the situation, and personal factors. Research suggests that emotion-focused strategies are used more often with uncontrollable events and can be more effective with events that are perceived as such (Forsythe & Compas, 1987). In general, data suggest that people who do not favor a specific coping style for a given situation or who attempt to use conflicting coping styles simultaneously cope less effectively and, hence, experience more emotional distress (Warburton et al., 1997).

Involvement coping (consisting of such behaviors as seeking social support, developing a plan of action, etc.) is related to decreased depressed mood. Holt et al.
Depression and Coping with HIV

(1998) conducted a qualitative investigation to explore the role of disclosure in HIV infection. A semi-structured interview format was used for the study after the participants completed a short demographic questionnaire. Participants were asked a series of open-ended questions pertaining to the interviewee’s sexual health, with particular emphasis on personal, interpersonal and service provision issues. The sample consisted of 40 gay and bisexual men with a mean age of 34 years (range 20-53 years). Of these, 92.5% were White European, 5% were White from elsewhere, and 2.5% were Asian. Approximately half of the sample was unemployed. Fifty-five percent of these individuals attributed their unemployment to their current health status and a further 37.5% classed themselves as unpaid employed, as they were working as volunteers within the HIV/AIDS sector. The data revealed that disclosing one’s HIV status was an acute and recurrent stressor. There was evidence that individuals increasingly used disclosure as a mechanism for coping with the disease. Disclosure of one’s status was used to increase both practical and emotional support, share responsibility for sex, and to facilitate self-acceptance of one’s condition. As mentioned earlier in a study by Zea, Reisen, Poppen, Bianchi, and Echeverry (2005) disclosure was associated with lower levels of depression.

Adaptive Coping: Individuals employing adaptive coping strategies such as actively seeking information and developing a “fighting spirit” have shown slower progression from an asymptomatic phase of HIV infection to the symptomatic phase, and better adjustment to this illness (Leserman, Perkins, & Evans, 1992; Solano et al., 1993). In a study by Simoni and Ng (2000), the researchers were particularly interested in learning if disclosure was related to more adaptive coping strategies, greater social support, and better psychological adaptation to HIV disease among women of African
descent (Latino Black and non-Latino Black). The women reported high rates of HIV disclosure to family, friends, and lovers; few differences in reporting were noted along ethnic lines. Analyses revealed disclosure was related to greater frequency of HIV-related social support. Additionally, disclosure rates were positively associated with the use of more adaptive coping strategies (e.g., spiritual resilience, constructive cognitions, and community involvement). Further analyses indicated that satisfaction with social support mediated the relationship between adaptive coping and psychological distress.

Another major finding was that coping can often be predicted by the level of perceived social support. Specifically, high support was linked to greater use of seeking support and positive coping, and low social support was linked to self-destructive coping. This is consistent with the idea that social support is a coping resource that facilitates adaptive coping (Holahan & Moos, 1994; Thoits, 1995).

*Maladaptive Coping:* In general, the use of maladaptive coping strategies such as avoidance and denial have been associated with higher depression and anxiety scores, less use of efficacious social networks, and poor psychological adjustment (Namir, Wolcott, Fawzy, & Alumbaugh, 1990; Reed, Kemeny, Taylor, Wang, & Visscher, 1994). Maladaptive coping strategies such as denial, avoidance, and substance use predict greater compromises in physical health such as HIV disease progression (Ironson et al., 1994; Penkower et al., 1991). Studies have shown significant associations between dysfunctional thinking patterns and maladaptive coping strategies such as avoidance and poor problem solving (Guppy & Weatherstone, 1997; Otto et al., 1997).

*Active Coping:* Carver, Scheier, and Weintraub (1989) defined active coping as the process of taking active steps to try to remove or circumvent the stressor or to
ameliorate its effects. Active coping includes initiating direct action, increasing one's efforts, and trying to execute a coping attempt in stepwise fashion. Active coping is very similar to the core of what Lazarus and Folkman (1984) call problem-focused coping. Individuals using more problem-focused strategies show lower levels of psychological distress subsequent to their traumas compared to those favoring emotion-focused strategies. Research indicates that active coping such as venting of emotions is one of the least used strategies among people with HIV (Wolf et al., 1991).

Avoidant Coping Styles: Findings on avoidant coping strategies are mixed and may be attributed to varying definitions (Herman, 1992). For example, avoidant coping defined as creativity and an ability to fantasize correlates with fewer psychological symptoms, suggesting that avoidance can be helpful (Dipalma, 1994). However, when avoidant coping is defined as withdrawal, it correlates with higher symptom levels (Frazier & Burnett, 1994). However, the use of avoidant strategies increases with symptomatology and with the length of time since HIV infection, perhaps due to diminished hopes of recovery. Such strategies also are more prevalent among disadvantaged patients, e.g., persons of color, intravenous drug users, women, and people with lower incomes (Fleishman & Fogel, 1994), and those with personality disorders (Perkins et al., 1993). Avoidant coping strategies correlate with higher levels of psychological distress, including depression (Fukunishi et al., 1997). On the other hand, some emotion-focused strategies, such as self-control and optimism, are associated with low levels of distress (Pakenham et al., 1994). Emotion-focused strategies correlating with higher symptom levels include avoidance of cues associated with the trauma and isolation (Frazier & Burnett, 1994).
Effective Coping Strategies: Effective problem-focused strategies may include rational actions, help-seeking behaviors, cognitive restructuring, religious activities, and humor (Fukunishi et al., 1997; Pakenham et al., 1994). Individuals have been known to cope with stress in various ways. HIV-positive individuals have also developed some coping strategies that have been described and validated by empirical studies as effective coping strategies. There is some evidence that HIV disclosure, although it serves as both an ongoing and acute stressor, facilitates emotional support, which may lead to more effective coping and enhanced psychological adaptation (Holt et al., 1998). Cruess et al. (2002) examined the effects of a cognitive–behavioral stress management (CBSM) intervention versus a no-treatment control group in 100 HIV-infected gay men. CBSM participants showed significant decreases in mood disturbance and depressive symptoms, as well as changes in coping, perceptions of social support, self-efficacy, and dysfunctional attitudes. Specifically, they increased their use of active coping and seeking social support for emotional reasons. Just as important, participants in the control condition appeared to abandon their use of acceptance, positive reinterpretation, and growth as coping strategies, whereas CBSM participants maintained these. CBSM participants also demonstrated increases in their perceptions of social support attachment, guidance, and reassurance of worth. The CBSM participants also showed increased self-efficacy and decreased distorted and dysfunctional attitudes (cognitive appraisal processes) over time. An active or problem-focused coping strategy has been identified as effective in many other studies (e.g., Carver, Scheier, & Weintraub, 1989; Fukunishi et al., 1997; Pakenham et al., 1994). The studies summarized above have highlighted
findings on active coping strategies. This present study seeks to further support and clarify the existing findings.

*The Ways of Coping and Concern and Coping with HIV:*

Folkman’s theory of coping gave rise to the various coping Scales that have been developed over the years like “The brief COPE” (Carver, Scheier, & Weintraub, 1989) and Concern and Coping with HIV Scale (CCHIV). The Concern and Coping with HIV scale used in this study was modified from the Ways of Coping instrument initially developed by Lazarus and Folkman (1986). The Ways of Coping Scale has eight factors: confrontive coping, distancing, self-controlling, seeking social support, accepting responsibility, escape-avoidance, planful problem-solving and positive reappraisal. The Ways of Coping Scale was normed with 108 undergraduates. Though the Ways of Coping Scale was developed to measure the stress that ordinary individuals are going through, HIV/AIDS did not exist then. Specific stress that has resulted from coping with HIV lead researchers to develop specific coping instruments that measure the stress associated with living with HIV/AIDS. The CCHIV categorized coping into nine factors: optimistic planning, involvement with the HIV community, social emotional support, spirituality, escape fantasies, self isolation, negative rumination, anger, and distancing. This is specific to the coping strategies among people living with HIV. The CCHIV is a relatively new instrument that was developed to measure concern and coping with HIV.

*Chapter summary*

This chapter has presented the impact of HIV/AIDS among African Americans and Latinos in the United States. It has also highlighted the various ways several cultures cope with HIV, and specifically, the relationship between HIV and coping among African
American and Latino communities. This chapter also reviewed the value of religion in coping with HIV, and social support and its relationship to coping. The mental health of African Americans and Latinos was also presented. The coping theory from Lazarus and Folkman (1984), who created the “The Ways of Coping Scale,” was also reviewed. The Concern and Coping with HIV Inventory and its relationship to the Ways of Coping Scale was also presented. The following chapter will present the details of the method of this study.
CHAPTER THREE

METHODOLOGY

This chapter describes methods and instrumentation used in this investigation. Sample selection, research design, data collection, and data analysis are presented, as are psychometric properties of the measures.

Population and Sample

A sample of 64 African-American and Latino men who had a diagnosis of Human Immunodeficiency Virus (HIV) was drawn from the Boston Living Center and Multicultural AIDS Coalition (MAC). As of December 2008, the Boston Living Center was reported to have an active membership of over 2,400 while the Multicultural AIDS Coalition was reported to be serving more than 100 HIV-positive members. These are healthcare agencies that provide services to people living with HIV in Boston. The inclusion criteria were African-American or Latino men, 18 years or above, who had received a diagnosis of HIV. The time since diagnosis, sexual orientation, marital status, and mode of transmission were investigated for African Americans and Latino men who are HIV-positive. Two men were eventually excluded from analysis given that they identified as neither African American nor Latino.

Data Collection Sites-Agencies

This investigator worked as a research assistant on a health disparities project that was funded by the Boston Public Health Commission. The project was aimed at introducing health system navigation in selected healthcare agencies in Boston. The agencies included the Multicultural AIDS Coalition (MAC), Roxbury Comprehensive Community Health Center, Mattapan Community Health Center, Dana Farber Cancer
Institute, and REACH Elders 2010 Coalition. A colleague who had worked with the Boston Living Center (BLC) as a practicum student recommended the BLC as a data collection site, and MAC was chosen because of familiarity with their program.

*The Boston Living Center (BLC)*

The Boston Living Center is reported to have an active membership of over 2,400 as of December 2008. The population includes HIV-positive individuals of all ages, genders, transmission categories, and ethnic backgrounds residing in the Greater Boston area, with some members coming as far as Southern New Hampshire and Connecticut. Their only criterion for membership is the verification of HIV-positive status. According to the BLC, their current membership is 79% male and 20% female. They also reported that 75% of their members were low income and/or receiving government assistance. All programs and services are provided to members of the BLC for free. Women account for the fastest growing population of the Center's new membership. The BLC has over 500 volunteers that donate their time and talents each year to teach classes and workshops, provide holistic therapies, prepare and serve meals, or work on special events committees. The Cornerstone Partners form the foundation of its donor base and provide the funds needed to sustain programs and services to its members.

*Multicultural AIDS Coalition (MAC)*

The mission of the Multicultural AIDS Coalition’s (MAC) mission is to mobilize communities of color to end the HIV/AIDS epidemic. It also works to ensure quality, accessible prevention and treatment services for people living with HIV, as well as those who are at risk for becoming infected, and those closely affected by the disease. According to MAC, it supports broader community efforts to eradicate conditions that
fuel the epidemic, including substance abuse, lack of healthcare access, homelessness, incarceration, and oppression based on race, ethnicity, gender, and sexual orientation. MAC has a priority on communities of color, and their “multicultural” focus extends beyond the boundaries of race and ethnicity. MAC honors the full cultural diversity in Boston’s communities, which includes the cultures of people in recovery; multiple faith communities; gay, lesbian, bisexual, and transgender individuals; people living and struggling with homelessness, domestic violence, or poverty; and others. MAC endeavors to exemplify excellence, integrity, innovation, and a culture of learning.

*Participants from the centers*

To get a clearer understanding of the men in this study, it will be necessary to understand the agencies that they were linked to and where the data was collected. One of the agencies had a program that was specifically designed for men having sex with men (MSM) irrespective of their HIV status. They also had another program that was designed for Latinos who were HIV positive. These men were registered members and had become familiar with each other and the staff of the agency. The members met regularly at a scheduled date and time where they shared a meal, engaged in discussion, and sometimes did something fun like watch a movie. The support system among members was strong although the age range varied; members interacted freely across age.

The second site had a more comprehensive approach, with scheduled trainings, daily hot meals for members, vocational and physical education, and more diversity in terms of ethnicity and gender. There were a lot more people present at this site and they also had more activities. One criterion for membership in this site was a positive diagnosis of HIV/AIDS. One common feature at both sites was the strong social support
provided to members by site staff. The sites are heavily staffed and managed by members who serve as both volunteer and paid employees. This creates both jobs and a sense of well-being for the members, who feel useful because of the jobs they hold at the site.

**Research Objectives**

This study was aimed at investigating depression and coping strategies among Black and Latino men living with HIV infection. Different cultures have different ways of coping with HIV infection based on how they perceive life. For example, African Americans and Latinos are often characterized as collectivist; the needs of the group precede that of the individual. The information gained from this research, it is hoped, will give mental health providers, policy makers, and people who are HIV positive greater insight into coping and greater empowerment to live their lives more fully.

**Research Variables**

This study investigated depression and coping (dependent-variable) among African-American and Latino men living with HIV. Independent (status) variables included demographic information such as sexual orientation, ethnicity, gender, and mode of HIV transmission.

**Procedure**

Study participants were identified in collaboration with healthcare agencies that provide services to people living with HIV. Flyers advertising the study were publicly displayed and invited HIV-positive men from the facilities to participate. At both MAC and the Boston Living Center, the investigator had a meeting with the program managers. The program managers set aside days when the investigator went to the sites and spoke to a group of between 10 to 20 HIV-positive men about the study. The research
questionnaires were given at the same time and collected as soon as they were completed. Participants were given gift cards as they returned their questionnaires. At the meetings, participants were informed about the study with the following introduction: “There is a study you might be interested in. The information is in the package on the table. You can fill the forms out and return it back to me to collect a $10 Dunkin Donuts gift card.” This non-aggressive method of sampling has been used in previous research and was developed through consultation with consumers; it was designed to respect the need for anonymity and to counter the reaction to being urged to participate in research (Friedland, Renwick, & McColl, 1996). The packages consisted of a consent form that required a signature, a demographic questionnaire adapted from the Robinson Resistance Modality Inventory (RRMI), the Concern and Coping with HIV Scale (CCHIV) (Jenkins & Guarnaccia, 2003), and the Beck Depression Inventory (BDI-II) (Beck, Steer, & Garbin, 1988).

Instrumentation

A demographic questionnaire adapted from the Robinson Resistance Modality Inventory (RRMI) queried HIV-positive Black and Latino patients about their gender, age, years of education, marital status, number of children, ethnicity, residence, sexual orientation, income, mode of HIV transmission, and length of time living with HIV/AIDS. The 37-item Concern and Coping with HIV Scales (CCHIV) is divided into nine factors: (1) escape fantasies, (2) self-isolation, (3) negative rumination, (4) anger, (5) distancing, (6) optimistic planning, (7) HIV community, (8) social-emotional support, and (9) spirituality. It was used to measure the coping strategies of people in the study. The original sample of the CCHIV included 270 anonymous HIV-positive clients.
recruited from a large county health department clinic, with a mean age range of 32.3 years. The CCHIV psychometric scales were developed with gay/bisexual men, heterosexual men, and women who were HIV positive. They self-identified as: 106 gay/bisexual men, 97 heterosexual women, 65 heterosexual men, and two lesbian women. The sample was 86% Caucasian, 8% African American, 5% Latino, and 1% other ethnic origin. The psychometric properties included a nine-factor LISREL measurement model that provided a reasonable fit: $X^2 [df = 593] = 1055$, $GFI = 0.81$, $RMSR = 0.06$). Intercorrelations and reliabilities of coping with HIV among the nine factors are: escape fantasies (0.57), self-isolation (0.73), negative rumination (0.61), anger (0.65), distancing (0.65), optimistic planning (0.82), HIV community (0.77), social-emotional support (0.64), and spirituality (0.75).

The Concern and Coping with HIV Scale was designed to elicit responses from patients who recently received their HIV test results. In the original scale, the instruction was: “Please circle a number for each item to show what you did after your test came back positive.” An example of a response included “Tried to keep your feelings to yourself.” The responses were rated on a Likert scale format, with “Not at all (0),” “Some (2),” and “Very often (4).” Other responses included; “Felt like a victim of fate”; “Explored your spirituality more deeply”; “Attended groups for HIV-infected people”; “Began or resumed individual counseling”; “Tried to figure out who gave you the virus”; “Turned to work to take your mind off things”; “Stood your ground and fought for what you wanted”; “Let your feelings out somehow”; “Thought about others you know who are HIV positive”; and “Avoided making new relationships.”
The Beck Depression Inventory (BDI-II) (Beck, Steer, & Garbin, 1988) was used for measuring the severity of depression among HIV-positive patients. The BDI-II is a 21-item self-report rating inventory measuring characteristic attitudes and symptoms of depression (Beck et al., 1961). In terms of reliability, the internal consistency of the BDI-II ranges from 0.73 to 0.92, with a mean of 0.86, and has a split half reliability coefficient of 0.93 (Beck, Steer, & Garbin, 1988). Concurrent validity is moderate. Correlations with clinician ratings of depression ranged from 0.62 to 0.66. Groth-Marnat (1990) reported moderate correlations between the revised BDI-II and other scales measuring depression, such as the Hamilton Psychiatric Rating Scale for Depression (0.73), the Zung Self Reported Depression Scale (0.76), and the MMPI Depression Scale (0.76).

Questions on the BDI-II are categorized into (1) sadness, (2) pessimism, (3) sense of failure, (4) dissatisfaction, (5) guilt, (6) expectation of punishment, (7) dislike of self, (8) self accusation, (9) suicidal ideation, (10) episodes of crying, (11) irritability, (12) social withdrawal, (13) indecisiveness, (14) change in body image, (15) retardation, (16) insomnia, (17) fatigability, (18) loss of appetite, (19) loss of weight, (20) somatic preoccupation, and (21) low level of energy. The highest score on each of the 21 questions is three; the highest possible total for the whole scale is 63. The lowest possible score is zero (0). Respondents are asked to respond with one score per question. Scores ranging from 5 - 9 are considered normal; scores 10 - 18 are considered to be mild to moderate depression; and 19 - 29 are considered to be moderate to severe depression. Scores of 30 - 63 are considered to be representative of severe depression. Responses to the sadness question are: “I do not feel sad (0), I feel sad (1), I am sad all the time and I can’t snap out of it (2), and I am so sad or unhappy that I cannot stand it (3).” Responses
to the failure question include: “I do not feel like a failure (0), I feel I have failed more than an average person (1), As I look back on my life, all I can see is a lot of failures (2), and I feel I am a complete failure as a person (3).” Responses about Insomnia include: “I can sleep as well as usual (0), I don’t sleep as well as I used to (1), I wake up 1-2 hours earlier than usual and find it difficult to get back to sleep (2), I wake up several hours earlier than I used to and cannot get back to sleep (3).”

Research Design and Data Analysis

A correlational design was used for this study. Two constructs were measured: depression and coping. Concern and Coping with HIV (CCHIV) scales measured coping. The Beck Depression Inventory (BDI-II) measured depression. A demographic questionnaire adapted from The Robinson Resistance Modality Inventory (RRMI) elicited socio-demographic information. Parametric analyses, Spearman correlation, two-way ANOVA, and t tests were employed to examine the relationships among variables.

Research Questions:

This study investigated five research questions on depression and coping among Black and Latino men living with HIV. The research questions are presented below.

1. Is there a difference in the levels of depression among Black and Latino HIV-positive men? To compare the levels of depression between Blacks and Latinos, an independent t test was calculated.

2. Is there a difference in the levels of coping among Black and Latino HIV-positive men? Results were analyzed using Multivariate Analysis of Variance (MANOVA) with the nine coping factors as the dependent variables and ethnicity as the independent variable.
3. Is there a relationship between depression and coping among Black and Latino HIV-positive men? A non-parametric Spearman bivariate correlation was calculated to examine the relationship between levels of depression and coping.

4. Is there a relationship between mode of HIV transmission and coping among Black and Latino HIV-positive men? The modes of HIV transmission included: sex, blood transfusion, injection drug use, birth, and accident. The results were analyzed using the two-way ANOVA ethnicity (Black and Latino) and mode of HIV transmission as the independent variables and overall coping as the dependent variable.

5. Is there a relationship between mode of HIV transmission and depression among Black and Latino HIV-positive men? The results were analyzed using a two-way ANOVA with ethnicity (Black and Latino) and mode of HIV transmission (sex, blood transfusion, injection drug use, and accident) as the independent variables and depression as the dependent variable.

This study attempted to make connections between past studies that identified various coping strategies and levels of depression among men living with HIV and current study participants. Using the new Coping and Concern with HIV scale, this study aimed to identify coping strategies and levels of depression among HIV-positive Black and Latino men.
CHAPTER FOUR

RESULTS

This chapter presents the results of the study. The study sample consisted of 64 African-American and Latino men who were HIV positive. First, the demographic characteristic of the entire sample is discussed. More specifically, information is provided on mode of HIV transmission, age diagnosed with HIV, sexual orientation, living arrangement, type of residence, marital status, education, employment, and religion. Analysis of the Beck Depression Inventory (BDI-II) and Coping with HIV Inventory (CCHIV) are also presented. Statistical analyses of the research questions are detailed. Finally, a summary of findings from the analyses is outlined.

Sample Characteristics

Of the 64 men, 26 were African American and 38 were Latino. Since this study focused on the two groups (African Americans and Latinos), the inclusion criterion was male and identification as either African American or Latino. Ethnic status for the two groups was determined by self-identification. Descriptive analyses of the demographic information are presented below.

Mode of HIV transmission: Mode of HIV transmission varied as well. Sixty-one percent of all the men contracted HIV through sex. Eighteen men (29%) reported that they contracted HIV through injection drug use. One man pointed out that he contracted HIV by accident (blood contact with an HIV-positive person during an accident), and two men (3%) stated that they did not know how they contracted HIV. The breakdown by ethnicity is as follows: 21 African-American men (84%) and 20 Latino men (53%) indicated sex as their mode of HIV transmission. Three African-American men (12%)
indicated that they acquired HIV through injection drug use, while 15 Latino men (40%) also stated they acquired HIV through injection drug use. See table 2 for a more detailed presentation of the mode of HIV transmission by ethnicity.

Table 2

<table>
<thead>
<tr>
<th>Mode of HIV Transmission</th>
<th>Ethnicity</th>
<th>African American</th>
<th>Latino</th>
<th>Total</th>
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<tbody>
<tr>
<td>Sex</td>
<td>% within Ethnicity</td>
<td>84%</td>
<td>53%</td>
<td>61%</td>
</tr>
<tr>
<td>Blood</td>
<td>Count</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>transfusion</td>
<td>% within Ethnicity</td>
<td>4%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Injection</td>
<td>Count</td>
<td>3</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>drug use</td>
<td>% within Ethnicity</td>
<td>12%</td>
<td>40%</td>
<td>29%</td>
</tr>
<tr>
<td>Accident</td>
<td>Count</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other/</td>
<td>Count</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>I don’t know</td>
<td>% within Ethnicity</td>
<td>0%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>25</td>
<td>38</td>
<td>63</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Age: Forty-one percent of the men identified as African American, while 59% identified as Latino. The men in this research study ranged from 25 to 62 years of age, with a mean age of 44 for the Latino men and 45 for the African-American men. Eighty-eight percent of the population ranged between the ages of 31 and 55 years. The breakdown of the ages is as follows: two men (3%) were between the ages of 25-30
years, six men (9%) were 31-35, twelve (19%) were 36-40, nineteen (30%) were 41-45, twelve men (19%) were 46-50, seven men (11%) were 51-55, and six (9%) were 56-62. Sixty-nine percent of Latino men were 41 years or older, while 65% of African-American men were 41 years or older.

Table 3

*Cross Tabulation of Age and Ethnicity*

<table>
<thead>
<tr>
<th>Age</th>
<th>Ethnicity</th>
<th>African American</th>
<th>Latino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-30</td>
<td>Count</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>0%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>31-35</td>
<td>Count</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>15%</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>36-40</td>
<td>Count</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>19%</td>
<td>18%</td>
<td>19%</td>
</tr>
<tr>
<td>41-45</td>
<td>Count</td>
<td>6</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>23%</td>
<td>34%</td>
<td>30%</td>
</tr>
<tr>
<td>46-50</td>
<td>Count</td>
<td>4</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>15%</td>
<td>21%</td>
<td>19%</td>
</tr>
<tr>
<td>51-55</td>
<td>Count</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>19%</td>
<td>5%</td>
<td>11%</td>
</tr>
<tr>
<td>56-62</td>
<td>Count</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>8%</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>26</td>
<td>38</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
*Year Diagnosed with HIV:* The year when participants were diagnosed with HIV varied widely. The earliest year of diagnosis was 1984 and the latest was 2007. Fifteen men (25%) were diagnosed with HIV between 1984-1990. Twelve men (18%) were diagnosed with HIV between 1991-1995, and 17 men (27%) were diagnosed between 2001-2008. See table 4 for the breakdown by ethnicity.

Table 4

*Year Diagnosed with HIV by Ethnicity Cross Tabulation*

<table>
<thead>
<tr>
<th>Year Diagnosed with HIV</th>
<th>Ethnicity</th>
<th>African American</th>
<th>Latino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984 – 1990</td>
<td>Count</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>19%</td>
<td>27%</td>
<td>25%</td>
</tr>
<tr>
<td>1991 – 1995</td>
<td>Count</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>19%</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>1996 – 2000</td>
<td>Count</td>
<td>10</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>38%</td>
<td>24%</td>
<td>30%</td>
</tr>
<tr>
<td>2001 – 2008</td>
<td>Count</td>
<td>6</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>23%</td>
<td>30%</td>
<td>27%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>26</td>
<td>37</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Sexual orientation: The majority of the men were heterosexual. Thirty-eight men (60%) identified as straight, 16 men (25%) identified as gay, and eight men (13%) identified as bisexual. One man did not indicate his sexual orientation. Three African-American men (12%) were bisexual, 10 (40%) were heterosexual, 11 (44%) were gay, and one African-American man did not specify his sexual orientation. See Table 5 below for the breakdown by ethnicity.

Table 5

**Sexual Orientation and Ethnicity Cross Tabulation**

<table>
<thead>
<tr>
<th>Sexual orientation</th>
<th>Ethnicity</th>
<th>African American</th>
<th>Latino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisexual</td>
<td>Count</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>12%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Straight</td>
<td>Count</td>
<td>10</td>
<td>28</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>40%</td>
<td>74%</td>
<td>60%</td>
</tr>
<tr>
<td>Gay</td>
<td>Count</td>
<td>11</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>44%</td>
<td>13%</td>
<td>25%</td>
</tr>
<tr>
<td>Other</td>
<td>Count</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>4%</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>25</td>
<td>38</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
**Living Arrangement:** In relation to the living arrangement, sixteen African-American men (64%) and 23 Latino men (61%) lived alone, while one man (4%) was living with a foster parent. Six African-American men (24%) were living with friends or relatives, and two African-American men (8%) lived with a partner or wife. Two men (3%) lived with their parents, 14 men (22%) lived with friends or relatives, six men (9%) lived with a partner or wife, and two men (3%) lived with their fiancé. The majority of the men (62%) indicated that they lived alone. Table 6 below has a detailed description of the living arrangement by ethnicity.

Table 6

**Living Arrangement by Ethnicity Cross Tabulation**

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Ethnicity</th>
<th>African American</th>
<th>Latino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living alone</td>
<td>Count</td>
<td>16</td>
<td>23</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>64%</td>
<td>61%</td>
<td>62%</td>
</tr>
<tr>
<td>Living with foster</td>
<td>Count</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>parents</td>
<td>% within Ethnicity</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Living with friends</td>
<td>Count</td>
<td>6</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>or relatives</td>
<td>% within Ethnicity</td>
<td>24%</td>
<td>21%</td>
<td>22%</td>
</tr>
<tr>
<td>Living with partner</td>
<td>Count</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>or wife</td>
<td>% within Ethnicity</td>
<td>8%</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Living with fiancé</td>
<td>Count</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>0%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>25</td>
<td>38</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Type of Residence: Six men (10%) lived in residential halls, eight men (13%) lived in shelters, five men (8%) lived in group homes, and 43 men (67%) lived in apartments/houses. Four African-American men (16%) lived in a residential hall (shelter), three African-American men (12%) lived in a shelter, and 17 African-American men (68%) lived in an apartment/house. Please see Table 7 for more information on the types of residence and the details in percentages by ethnicity.

Table 7

<table>
<thead>
<tr>
<th>Type of Residence</th>
<th>Ethnicity</th>
<th>African American</th>
<th>Latino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential hall</td>
<td>Count</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>16%</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Shelter</td>
<td>Count</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>12%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Group home</td>
<td>Count</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>0%</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Apartment/House</td>
<td>Count</td>
<td>17</td>
<td>26</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>68%</td>
<td>68%</td>
<td>68%</td>
</tr>
<tr>
<td>Other</td>
<td>Count</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>4%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>25</td>
<td>38</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
**Marital Status:** The breakdown of marital status was as follows: 38 men (60%) had never married, 15 men (24%) were divorced, five men (8%) were married, four men (6%) were separated, and one man was widowed. See Table 8 for full details of marital status by ethnicity.

Table 8

**Marital Status by Ethnicity Cross Tabulation**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Ethnicity</th>
<th>African American</th>
<th>Latino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never married</td>
<td>Count</td>
<td>19</td>
<td>19</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>76%</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>Married</td>
<td>Count</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>4%</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Divorced</td>
<td>Count</td>
<td>2</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>8%</td>
<td>34%</td>
<td>24%</td>
</tr>
<tr>
<td>Separated</td>
<td>Count</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>8%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Widowed</td>
<td>Count</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>4%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>25</td>
<td>38</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Children: Thirty men (48%) stated that they did not have children, while 33 men (53%) stated that they had children. See table 9 for a breakdown of the percentages of children by ethnicity.

Table 9

Number of Children by Ethnicity Cross Tabulation

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Ethnicity</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>African American</td>
<td>Latino</td>
<td>Total</td>
</tr>
<tr>
<td>I do not have children</td>
<td>Count</td>
<td>15</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>60%</td>
<td>40%</td>
<td>48%</td>
</tr>
<tr>
<td>I have children</td>
<td>Count</td>
<td>10</td>
<td>23</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>40%</td>
<td>61%</td>
<td>53%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>25</td>
<td>38</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Level of Education: Level of education attained by the sample population varied. Forty-five men (71%) had graduated from high school, eight men (13%) had some college education, and three of the men (5%) had attained a bachelor’s degree. One man indicated he was currently enrolled in college. One man had an associate’s degree and five men had achieved a master’s degree. See Table 10 below for a detailed presentation of the educational level according to ethnicity.

Table 10

Highest Level of Education by Ethnicity

<table>
<thead>
<tr>
<th>Highest Level of Education</th>
<th>African American</th>
<th>Latino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School</td>
<td>13</td>
<td>32</td>
<td>45</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td>52%</td>
<td>84%</td>
<td>71%</td>
</tr>
<tr>
<td>Some College</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td>20%</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td>Currently enrolled in College</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td>4%</td>
<td>0%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Associate Degree</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td>0%</td>
<td>3%</td>
<td>1.5%</td>
</tr>
<tr>
<td>BA, BS</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td>8%</td>
<td>3%</td>
<td>4.5%</td>
</tr>
<tr>
<td>MA, MS</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td>20%</td>
<td>3%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>38</td>
<td>63</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
**Employment:** With regards to employment, 10 men (16%) were employed, while 53 men (84%) were unemployed. Table 11 presents the percentage of African Americans and Latinos employed and those who are unemployed among this study group.

Table 11

*Employment Status by Ethnicity Cross Tabulation*

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Ethnicity</th>
<th>African American</th>
<th>Latino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>Count</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>20%</td>
<td>13%</td>
<td>16%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>Count</td>
<td>20</td>
<td>33</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>80%</td>
<td>87%</td>
<td>84%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>25</td>
<td>38</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>% within Ethnicity</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
**Religion:** Regarding religion, the majority of the sample – 54 men (86%) identified as Christians. One man identified as agnostic, and another as atheist. Two other men (3%) identified as Buddhist and five men (8%) indicated that they did not have a religion. Table 12 has a detailed description of religion by ethnicity.

Table 12

*Religion by Ethnicity Cross Tabulation*

<table>
<thead>
<tr>
<th>Religion</th>
<th>Count</th>
<th>Ethnicity</th>
<th>African American</th>
<th>Latino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agnostic</td>
<td></td>
<td></td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% within Ethnicity</td>
<td>4%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Atheist</td>
<td></td>
<td></td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% within Ethnicity</td>
<td>4%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Buddhist</td>
<td></td>
<td></td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% within Ethnicity</td>
<td>8%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Christian</td>
<td></td>
<td></td>
<td>18</td>
<td>36</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% within Ethnicity</td>
<td>72%</td>
<td>95%</td>
<td>86%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% within Ethnicity</td>
<td>12%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>25</td>
<td>38</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% within Ethnicity</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Clinical Ranges for Depression

This section describes the clinical ranges of depression as measured by the Beck Depression Inventory for the sample. Sixty-four African-American and Latino men responded to the Beck Depression Inventory (BDI-II). Thirty-two men (50%) had minimal depression, 10 men (16%) had mild depression scores, 14 men (22%) had moderate depression, and eight men (13%) had severe depression.

The level of depression among African-American and Latino men is presented as follows. Fourteen African-American men (54%) had minimal depression, five African-American men (19%) had mild depression, two African-American men (8%) had moderate depression, and five African-American men (19%) had severe depression. The breakdown for the Latino group is as follows: 18 Latino men (47%) had minimal depression, five Latino men (13%) had mild depression, 12 Latino men (32%) had moderate depression, and three Latino men (8%) had severe depression. In comparison, 27% of African Americans had moderate to severe depression, while 40% of the Latinos also had moderate to severe depression. It is also worth noting that a high percentage of the two groups had minimal depression. However, it is important to note that 35% of the sample had moderate and severe levels of depression. Table 13 shows the levels of depression by ethnicity while table 14 shows descriptive statistics for depression.
Table 13

*Depression ranges by Ethnicity*

<table>
<thead>
<tr>
<th>Levels of Depression/range</th>
<th>Ethnicity</th>
<th>African American</th>
<th>Latino</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal (0-13)</td>
<td>Count</td>
<td>14</td>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td>54%</td>
<td>47%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Mild (14-19)</td>
<td>Count</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td>19%</td>
<td>13%</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Moderate (20-28)</td>
<td>Count</td>
<td>2</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td>8%</td>
<td>32%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Severe (29-63)</td>
<td>Count</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td>19%</td>
<td>8%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>26</td>
<td>38</td>
<td>64</td>
</tr>
<tr>
<td>% within Ethnicity</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Table 14

*Descriptive statistics for Depression*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimal</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression (BDI-II total)</td>
<td>64</td>
<td>1</td>
<td>4</td>
<td>1.97</td>
<td>1.112</td>
</tr>
</tbody>
</table>

*Levels of Depression*

**Research Question #1:** The first research question of this study asked if there was a difference in the level of depression among Black and Latino HIV-positive men. The hypothesis was that there would not be a difference in the levels of depression among African-American and Latino HIV-positive men. To compare the levels of depression
between the two groups of men, an independent t test was calculated. No significant difference was found ($t(62) = .056, p > .05$). Mean scores on the Beck Depression Inventory (BDI-II) were analyzed. The mean BDI-II score for the African-American group ($m = 16.38, sd = 14.29$) was not significantly different from the mean score of the Latino group ($m = 16.21, sd = 10.51$). See table 15 for the significant value and t scores.

In other words African-American men and Latino men experienced similar levels of depression overall. Although there was not a significant difference in depression between Black and Latino men, there are some important findings. Frequency distribution of depression scores among African Americans and Latinos indicated that out of the 64 men that responded to the inventory, 8% of African-American men had moderate depression, compared to 32% of Latino men who reported moderate depression. Nineteen percent of African-American men had severe depression, compared to 8% of Latino men, although there was no significant difference in depression between the two ethnic groups. Among this sample, more Latino men than African-American men had moderate depression, whereas more African-American men than Latino men had severe depression. Table 15 shows the t test values for levels of depression.

Table 15

<table>
<thead>
<tr>
<th>Depression</th>
<th>F</th>
<th>sig.</th>
<th>t</th>
<th>df.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI-II</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>2.09</td>
<td>.153</td>
<td>.056</td>
<td>62</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>.053</td>
<td>42.962</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Levels of Coping

Research Question #2: Is there a difference in the levels of coping among Black and Latino HIV-positive men? Analysis was also conducted to find out the levels of coping among Black and Latino HIV-positive men. The hypothesis was that there would be similar levels of coping among Black and Latino men living with HIV. Results were analyzed using Multivariate Analysis of Variance (MANOVA) with the nine coping factors as the dependent variables and ethnicity as the independent variables. A one-way MANOVA was calculated to investigate any difference in the levels of coping (optimistic planning, HIV community, social-emotional support, spirituality escape fantasy, self-isolation, negative rumination, anger, and distancing) on ethnicity (African Americans and Latinos). No significant effect was found ($\Lambda(9,54) = .861$, $p > .05$). The result confirms the hypothesis that there is no difference in the levels of coping among African-American and Latino HIV-positive men. See table 16 for the multivariate test figures from MANOVA. Table 17 presents the descriptive statistics of the coping scores from CCHIV.
Table 16

Multivariate Tests

<table>
<thead>
<tr>
<th>Effect</th>
<th>Value</th>
<th>F</th>
<th>Hypothesis df</th>
<th>Error df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pillai’s Trace</td>
<td>.97</td>
<td>1.75</td>
<td>9.00</td>
<td>54.00</td>
<td>.00</td>
</tr>
<tr>
<td>Wilks’ Lambda</td>
<td>.03</td>
<td>1.75</td>
<td>9.00</td>
<td>54.00</td>
<td>.00</td>
</tr>
<tr>
<td>Hotelling's Trace</td>
<td>29.32</td>
<td>1.75</td>
<td>9.00</td>
<td>54.00</td>
<td>.00</td>
</tr>
<tr>
<td>Roy's Largest Root</td>
<td>29.32</td>
<td>1.75</td>
<td>9.00</td>
<td>54.00</td>
<td>.00</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pillai's Trace</td>
<td>.14</td>
<td>.97</td>
<td>9.00</td>
<td>54.00</td>
<td>.47</td>
</tr>
<tr>
<td>Wilks' Lambda</td>
<td>.86</td>
<td>.97</td>
<td>9.00</td>
<td>54.00</td>
<td>.47</td>
</tr>
<tr>
<td>Hotelling's Trace</td>
<td>.16</td>
<td>.97</td>
<td>9.00</td>
<td>54.00</td>
<td>.47</td>
</tr>
<tr>
<td>Roy's Largest Root</td>
<td>.16</td>
<td>.97</td>
<td>9.00</td>
<td>54.00</td>
<td>.47</td>
</tr>
</tbody>
</table>
Table 17

*Descriptive statistics of the coping scores from CCHIV*

<table>
<thead>
<tr>
<th>Coping factors</th>
<th>Ethnicity</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td>African American</td>
<td>26</td>
<td>3.25</td>
<td>.89</td>
<td>.17</td>
</tr>
<tr>
<td></td>
<td>Latino</td>
<td>38</td>
<td>3.41</td>
<td>.90</td>
<td>.15</td>
</tr>
<tr>
<td>HIV community</td>
<td>African American</td>
<td>26</td>
<td>3.13</td>
<td>1.18</td>
<td>.23</td>
</tr>
<tr>
<td></td>
<td>Latino</td>
<td>38</td>
<td>3.38</td>
<td>.64</td>
<td>.10</td>
</tr>
<tr>
<td>Social-emotional support</td>
<td>African American</td>
<td>26</td>
<td>3.26</td>
<td>1.14</td>
<td>.22</td>
</tr>
<tr>
<td></td>
<td>Latino</td>
<td>38</td>
<td>3.21</td>
<td>.94</td>
<td>.15</td>
</tr>
<tr>
<td>Spirituality</td>
<td>African American</td>
<td>26</td>
<td>3.41</td>
<td>1.23</td>
<td>.24</td>
</tr>
<tr>
<td></td>
<td>Latino</td>
<td>38</td>
<td>3.33</td>
<td>1.19</td>
<td>.19</td>
</tr>
<tr>
<td>Fantasies</td>
<td>African American</td>
<td>26</td>
<td>2.86</td>
<td>.10</td>
<td>.20</td>
</tr>
<tr>
<td></td>
<td>Latino</td>
<td>38</td>
<td>3.25</td>
<td>.83</td>
<td>.14</td>
</tr>
<tr>
<td>Self-isolation</td>
<td>African American</td>
<td>26</td>
<td>2.78</td>
<td>.86</td>
<td>.17</td>
</tr>
<tr>
<td></td>
<td>Latino</td>
<td>38</td>
<td>2.93</td>
<td>.63</td>
<td>.10</td>
</tr>
<tr>
<td>Negative rumination</td>
<td>African American</td>
<td>26</td>
<td>2.58</td>
<td>1.03</td>
<td>.20</td>
</tr>
<tr>
<td></td>
<td>Latino</td>
<td>38</td>
<td>2.88</td>
<td>.79</td>
<td>.13</td>
</tr>
<tr>
<td>Anger</td>
<td>African American</td>
<td>26</td>
<td>2.12</td>
<td>.96</td>
<td>.19</td>
</tr>
<tr>
<td></td>
<td>Latino</td>
<td>38</td>
<td>2.32</td>
<td>1.04</td>
<td>.17</td>
</tr>
<tr>
<td>Distancing</td>
<td>African American</td>
<td>26</td>
<td>2.12</td>
<td>.96</td>
<td>.18</td>
</tr>
<tr>
<td></td>
<td>Latino</td>
<td>38</td>
<td>3.10</td>
<td>.74</td>
<td>.12</td>
</tr>
<tr>
<td>Overall coping</td>
<td>African American</td>
<td>26</td>
<td>2.89</td>
<td>.69</td>
<td>.14</td>
</tr>
<tr>
<td></td>
<td>Latino</td>
<td>38</td>
<td>3.05</td>
<td>.50</td>
<td>.08</td>
</tr>
</tbody>
</table>
Depression and Coping

Research Question #3: Is there a relationship between depression and coping among Black and Latino HIV-positive men? The hypothesis was that there would be a relationship between depression and coping among Black and Latino HIV-positive men.

To calculate this, Spearman bivariate correlation was used to evaluate the relationship between depression, overall coping, and coping subscores (optimistic planning, negative rumination, HIV community, self-isolation, distancing, spirituality, social-emotional support, escape fantasy, and anger) for coping at $p < .05$.

Results show a significant negative relationship between depression and planning, spirituality, and overall coping. This means that spirituality, as a means to cope, is associated with lower symptoms of depression as reported earlier in studies (Carrico et al., 2006; Simoni & Ortiz, 2003; Woods, Antoni, Ironson, & Kling, 1999). Those who are involved in planning about their life in relation to their HIV infection are also less depressed. Those who are coping well are also less depressed. There was also a significant positive relationship between depression and anger. This means higher levels of depression are associated with higher levels of anger. The correlation scores between coping and depression are presented in table 18.
Table 18

*Correlation between Depression Score and Coping Scores, n = 64*

<table>
<thead>
<tr>
<th>Coping Scores/Depression scores</th>
<th>Correlation Coefficient</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning/Depression</td>
<td>-0.352</td>
<td>0.002**</td>
</tr>
<tr>
<td>HIV Community/Depression</td>
<td>-0.171</td>
<td>0.088</td>
</tr>
<tr>
<td>Social-Emotional Support/Depression</td>
<td>-0.133</td>
<td>0.147</td>
</tr>
<tr>
<td>Spirituality/Depression</td>
<td>-0.355</td>
<td>0.003**</td>
</tr>
<tr>
<td>Fantasies/Depression</td>
<td>-0.146</td>
<td>0.125</td>
</tr>
<tr>
<td>Self Isolation/Depression</td>
<td>0.009</td>
<td>0.471</td>
</tr>
<tr>
<td>Negative Rumination/Depression</td>
<td>-0.014</td>
<td>0.455</td>
</tr>
<tr>
<td>Anger/Depression</td>
<td>0.305</td>
<td>0.007**</td>
</tr>
<tr>
<td>Distancing/Depression</td>
<td>-0.175</td>
<td>0.084</td>
</tr>
<tr>
<td>Overall Coping/Depression</td>
<td>-0.245</td>
<td>0.025*</td>
</tr>
</tbody>
</table>

Mode of HIV Transmission and Coping among Black and Latino HIV-positive men

Research Question #4: Is there a relationship between mode of HIV transmission and coping among Black and Latino HIV-positive men? This study explored the relationship between mode of HIV transmission and coping. The hypothesis was that based on the mode of HIV transmission, participants will be coping differently. For example, those who contracted HIV through sex with other men would cope differently from those who contracted HIV from blood transfusion. The reason being related to stigma associated with HIV/AIDS and homophobic attitudes, in particular within the African-American and Latino communities. The results were analyzed using the two-way ANOVA with
ethnicity (Black and Latino) and mode of HIV transmission (sex, blood transfusion, injection drug use, accident and other/I don’t know) as the independent variable, and overall coping as the dependent variable. The 2 (ethnicity) X 5 (mode of HIV transmission) between-subjects two-way ANOVA was calculated comparing overall coping and ethnicity. The main effect for ethnicity was not significant ($F(1,56) = .70, p > .05$). The main effect for mode of HIV transmission was also not significant ($F(4,56) = .35, p > .05$). Finally, the interaction was not significant ($F(1,56) = .09, p > .05$). Thus, mode of HIV transmission had no significant relationship with coping among Black and Latino HIV-positive men in this sample. Table 19 shows the ANOVA values for overall coping and mode of HIV transmission.

Table 19

*Tests of Between-Subjects Effects Dependent Variable: Coping*

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>.637</td>
<td>6</td>
<td>.106</td>
<td>.326</td>
<td>.920</td>
</tr>
<tr>
<td>Intercept</td>
<td>112.295</td>
<td>1</td>
<td>112.295</td>
<td>345.269</td>
<td>.000</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>.224</td>
<td>1</td>
<td>.224</td>
<td>.689</td>
<td>.410</td>
</tr>
<tr>
<td>HIV Transmission</td>
<td>.453</td>
<td>4</td>
<td>.113</td>
<td>.349</td>
<td>.844</td>
</tr>
<tr>
<td>Ethnicity*HIV Transmission</td>
<td>.028</td>
<td>1</td>
<td>.028</td>
<td>.087</td>
<td>.770</td>
</tr>
<tr>
<td>Error</td>
<td>18.213</td>
<td>56</td>
<td>.325</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>590.329</td>
<td>63</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>18.850</td>
<td>62</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Mode of HIV Transmission and Depression among Black and Latino HIV-positive men**

Research question #5: Is there a relationship between mode of HIV transmission and depression among Black and Latino HIV-positive men? The hypothesis was that there would be a relationship between mode of transmission and depression. The results were analyzed using a two-way ANOVA with ethnicity (Black and Latino) and mode of HIV transmission (sex, blood transfusion, injection drug use, accident and other/I don’t know) as the independent variable and depression as the dependent variable. The 2 (ethnicity) X 5 (mode of HIV transmission) between-subjects two-way ANOVA was calculated comparing depression and ethnicity. The main effect for ethnicity was not significant ($F(1,56) = .86, \ p > .05$). The main effect for mode of HIV transmission was also not significant ($F(4,56) = 1.67, \ p > .05$). Finally, the interaction was not significant ($F(1,56) = 1.67, \ p > .05$). Table 20 shows the ANOVA values for depression and mode of HIV transmission.
Table 20

Tests of Between-Subjects Effects Dependent Variable: Depression

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>8.679</td>
<td>6</td>
<td>1.447</td>
<td>1.186</td>
<td>.327</td>
</tr>
<tr>
<td>Intercept</td>
<td>46.449</td>
<td>1</td>
<td>46.449</td>
<td>38.082</td>
<td>.000</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>1.053</td>
<td>1</td>
<td>1.053</td>
<td>.863</td>
<td>.357</td>
</tr>
<tr>
<td>HIV Transmission</td>
<td>8.164</td>
<td>4</td>
<td>2.041</td>
<td>1.673</td>
<td>.169</td>
</tr>
<tr>
<td>Ethnicity*HIV Transmission</td>
<td>2.048</td>
<td>1</td>
<td>2.048</td>
<td>1.679</td>
<td>.200</td>
</tr>
<tr>
<td>Error</td>
<td>68.305</td>
<td>56</td>
<td>1.220</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>325.000</td>
<td>63</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>76.984</td>
<td>62</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thus mode of HIV transmission has no significant relationship with depression among Black and Latino HIV-positive men in this sample. The analysis indicates that there is no relationship between the mode of HIV transmission and levels of depression among African-American and Latino HIV-positive men. The method of HIV contraction has no significant effect on levels of depression.

Summary of Findings

The Ways of Coping (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986) provided the basis for the development of CCHIV that was used in measuring the coping strategies in this study. The instrument was normed with African-American, Latino, heterosexual, gay, and bisexual men and women. The Beck Depression Inventory (BDI-II) was used to measure the levels of depression among the study participants. In
summary, 26 African Americans and 38 Latinos responded to the inventories. The age of
the men ranged between 25 and 62 years, with a mean age of 44. Eighty-five percent of
the sample ages ranged from 32 to 54 years. Among the 26 African Americans who
responded to the Beck Depression Inventory (BDI-II), 74% had minimal to mild
depression, while 26% had moderate to severe depression. Thirty-eight Latinos
completed the BDI-II, of which 60% had minimal to mild depression, and 40% had
moderate to severe depression. There was no significant difference in depression scores
between Latino and Black men. However, according to BDI-II scores, 8% of African-
American HIV-positive men in the study had moderate depression, compared to 32% of
Latino men. Nineteen percent of African Americans had severe depression, compared to
8% of Latino men.

According to the CDC (2009), at the end of 2007, male-to-male sexual contact
accounted for 46% of the HIV transmission among African-American adolescents and
adults, compared to 59% for Latino adolescent and adult men. High risk heterosexual
contact made up 19% of the HIV transmission among African-American adolescent and
adult males, compared to 10% of the Latino adolescent and adult males. Injection drug
use constituted 26% of the mode of HIV transmission among African American males,
while Latino adolescent and adult male injection drug users constituted 23%. Therefore,
according to the CDC, male-to-male sexual contact among Latinos is the highest mode of
HIV transmission among people of color. Male-to-male sexual contact is also the highest
mode of HIV transmission among African-American men.

According to the findings of this study, a combined total of 84% African-
American men contracted HIV through sex. The percentage includes male-to-male sexual
contact and high risk heterosexual contact. CDC data at the end of 2007 indicates that 65% of African-American men contracted HIV through sex. This study shows that male-to-male sexual contact has continued to become an increasing mode of HIV transmission among African-American men. Injection drug use (12%) was the second highest mode of HIV transmission even though the variance is high, 84% compared to 12% for African-American men. The implication is that African-American men are contracting HIV at an increasing rate through sex rather than injection drug use.

For Latino men in this study, a combination of high-risk sex acts (male-to-male and high risk heterosexual contact) made up 61% of the mode of HIV transmission, compared to 69% from the CDC data at the end of 2007. The number of Latino men who reported injection drug use as their mode of HIV transmission was 29%, close to the 23% from the CDC data at the end of 2007. Injection drug users are noted for high-risk sexual behavior. According to Oliver-Velez et al. (2003), injection drug users engage in unprotected sex in an exchange for drug (heroin or crack).

In summarizing the results, a look at the research questions and their findings will follow. The first research question investigated difference in the levels of depression among African-American and Latino HIV-positive men. The hypothesis was that there would not be a difference in the levels of depression among African-American and Latino HIV-positive men. The hypothesis was confirmed as analysis indicated that there was no significant difference in the levels of depression among African-American and Latino men in the study.

The second research question investigated the difference in the levels of coping among African-American and Latino HIV-positive men. The hypothesis was that there
would be similar levels of coping among the two ethnic groups. The hypothesis was confirmed, as results indicated no significant difference in the overall coping among African-American and Latino HIV-Positive men.

In question three, the study investigated the relationship between depression and coping among African-American and Latino HIV-positive men. The hypothesis was that there would be a significant relationship between depression and coping among African Americans and Latinos. The result indicated a significant relationship between overall coping and depression scores. Specifically, there was a significant negative correlation between depression, optimistic planning, and spirituality. This implies that spirituality is associated with less depression and that those who are involved in optimistic planning are less depressed. Those who are angry are also more depressed. Therefore, the hypothesis was also confirmed, as there was a significant correlation between coping and depression.

The fourth question asked if there was a relationship between mode of HIV transmission and coping. Here again, the hypothesis was that there would be a significant relationship between mode of HIV transmission and coping. The idea was that due to the homophobic attitudes of African-American and Latino families, men who contract HIV through male-to-male sexual contact would not cope well due to the stigma and lack of support from their families. The results from the study did not confirm the hypothesis. There was no significant relationship between mode of HIV transmission and coping for African-American and Latino HIV-positive men. Finally, the last research question investigated the relationship between mode of HIV transmission and depression. Here the hypothesis was that there would be a significant relationship between mode of HIV transmission and depression. Again the hypothesis was not confirmed, as results did not
indicate a significant relationship between mode of HIV transmission and depression. The lack of a significant relationship in this case also indicates that HIV-positive African Americans’ and Latinos’ levels of depression were not predicted by the mode of HIV transmission.
CHAPTER FIVE

DISCUSSION

The purpose of the study was to identify the coping strategies that urban-based African-American and Latino HIV-positive men employ in the management of their HIV infection. The study also sought to explore the levels of depression among African Americans and Latinos who were HIV-positive. The research questions discussed in chapter one informed analysis of the data. The existing literature was integrated to frame the discussion of the research findings. First, primary study findings are presented followed by socio-demographic data. Study limitations, implications for future research, policy, and clinical practice conclude this chapter.

Primary Study Findings

Finding One

Levels of depression: Findings indicated that there was no significant difference in the levels of depression among African-American and Latino HIV-positive men. Although there was no significant difference between the two groups, there were HIV positive men in this study who were depressed. The results indicated that there were HIV-positive men who were depressed and would most likely benefit from mental health care. The percentage of African-Americans and Latinos who had minimal depression was 50%. With regards to moderate depression, 8% of African American men had moderate depression, compared to 32% of Latino men. Nineteen percent of African-American men had severe depression, while 8% of Latino men’s scores fell within a similar range.

Figure 1 below summarizes the study and figure 2 presents study implications.
Figure 1. Summary of the study

The Relationship Between Depression and Coping among Black and Latino Men Living with HIV/AIDS

**The purpose of the study**

1. The purpose is to identify the relationship between depression and coping among African-American and Latino HIV-infected men.

**Statement of the problem**

Although African-Americans and Latinos have high numbers of men living with HIV, little is known about the levels of depression and coping among them.

**African-Americans and Latinos**

African Americans and Latinos share common cultural values, e.g., they tend to struggle with group values and personal gains. Those who bring shame upon their families are often excluded or abandoned. Spirituality is valued.

**Folkman and Lazarus Coping Theory**

![Equation](Latinos (L) - 38 + African Americans (AA) - 26 = N - 64)

**Independent variable**

- Mode of HIV transmission:
  - AA: Sex 84%, L: Sex 53%
  - AA: IV 17%, L: IV 10%
- Age Diagnosed: AA 41 & L = 25
- Mean Age: AA 45; L 44
- Living arrangement: AA 64%; L 61% LA
- Sexual orientation: AA 40% = S, L 74% = S
- Place of residence: AA 68%; L 68% = II, AA 28%; 31% = GL
- Marital Status: AA 76% = NM, L 50% = NM
- Have Children: AA 40%; L 61%
- Education: AA CD 28%; L CD 36%
- Unemployment: AA = 85%, L = 87%
- Religion: AA 72%, C = 95%

**Dependent Variable**

- Optimistic planning, spirituality, and anger
- Coping CCIIV
- Depression BDI-II

**Primary study findings**

1. No difference in the levels of depression among African-American and Latino HIV+ men.
2. No difference in the levels of coping among African American and Latino HIV+ men.
3. There was a relationship between depression and overall coping among the sample population (optimistic planning, spirituality, and anger specifically).
4. Mode of HIV transmission was not related to coping.
5. Mode of HIV transmission was not related to depression.

**Implications for Future Research, Policy, and Clinical Practice**

- **Policy**: Promote safe sex and promote programs that put men back to work.
- **Future Research**: Include men and women in future studies. More research on high rate of unemployment among HIV+ men.
- **Clinical Practice**: Refer clients to agencies that offer psychosocial services to HIV+ men.
One explanation for the lack of statistical difference in the levels of depression among African Americans and Latinos could be attributed to the two groups’ participation and help-seeking from agencies that provide support to people living with HIV. It should be noted that the HIV-positive men in this study were all receiving services from the Boston Living Center and Multicultural AIDS Coalition. It is possible that the high percentages of minimal depression recorded among this group are explained by the psychosocial support they received from BLC and MAC. An important question to consider is why these men were receiving services and seeking support from BLC and MAC if they had adequate support from families and friends. A possible lack of family support may have precipitated HIV-positive individuals to seek support from HIV agencies. Another explanation could also be that HIV-positive men were not receiving support from their families due to the stigma of HIV in the African-American and Latino communities. There is also something psychologically powerful about being in the company of similar others.

The fact that half of the men in the study (African Americans and Latinos) demonstrated minimal depression (50%) is noteworthy. Peterson, Folkman, and Bakeman (1996) reported that social support and coping could either buffer or eliminate the effects of stress and, thus, decrease depressive symptomatology. As stated earlier, there is evidence that in the advent of highly active antiretroviral therapy (HAART), there may be a decrease in mood disorders among HIV-positive individuals (Rabkin, Ferrando, Lin, Sewell, & McElhiney, 2000). Most of the participants in this study were taking Anti Retroviral drugs. Therefore, the combination of HAART, involvement in HIV
community, optimistic planning, and spiritual coping could explain the high percentage of men with minimal depression among the participants in this study.

Peterson and colleagues (Peterson, Folkman, & Bakeman, 1996) found that psychosocial resources moderated the effects of stressors, hassles, and life events on depressive mood. At BLC and MAC, the men interacted with one another and offered support to each other. They networked, shared information about other places where services are offered to HIV-positive individuals. Discussion with the participants during the data collection process indicated that they were very aware of and connected to agencies that provide services to people living with HIV/AIDS. In this study, there was also a significant relationship between optimistic planning and lower levels of depression among the participants. Boston Living Center and MAC offered an environment for HIV-positive individuals to seek and obtain social support and plan about their lives. It was observed that HIV-positive men were very much involved in their care at the sites. Lazarus and Folkman classified this type of coping as problem-focused coping (rational actions, help-seeking behaviors, cognitive restructuring, religious activities, and humor), which have been associated with lower levels of psychological distress (Fukunishi et al., 1997; Pakenham et al., 1994).

**Finding Two**

*Levels of coping:* This study utilized a coping inventory that was normed on a population with characteristics similar to this study population. The Concern and Coping with HIV (CCHIV) was used to measure levels of coping. The norming samples were people infected with HIV. Findings indicated that African-Americans and Latinos had similar levels of coping. There was no significant difference between the levels of coping
among African Americans and Latinos. The lack of difference in the levels of coping among African Americans and Latinos was predicted. The similarities in the living arrangement and place of residence may further explain the lack of difference in the levels of coping among African Americans and Latinos in this study. The results showed that 64% of the African Americans and 61% of the Latinos were living alone. Again, an equal number of men- 68% of both African-Americans and Latinos - were living independently, which may also explain a lack of significant difference in the results. Living alone might have motivated these men to seek support from agencies that offer services to people living with HIV/AIDS. The participants in this study were seen advocating for services rather than avoiding helpful services. The participants engaged in a variety of activities that ranged from vocational to psychosocial activities. Again, both African-American and Latino HIV-positive men engaged in these activities, which could also explain the lack of difference in coping among the two groups. The findings in this study indicated that the participants utilized both emotion-focused and problem-focused coping. An example of how the participants used emotion-focused coping include behavior like going out to seek psychosocial support from agencies that offer services to individuals living with HIV/AIDS. Again results indicated that HIV-positive men in this study were busy planning for their care. Lazarus and Folkman’s coping theory was helpful to understand the coping strategies of the HIV-positive men in this study. A helpful element of this theory is that it allows one to understand the types of stressful situations that people undergo. It is difficult to classify some coping strategies as strictly emotion-focused and problem-focused. Behavior like seeking help from agencies that offer services to people living with HIV, which is used to regulate stress (emotion-
focused), can also be seen as problem-focused. It is problem-focused because the HIV-positive individual is trying to manage the problem (HIV) that is causing the distress.

Lazarus and Folkman’s coping theory was the theoretical base for studying the HIV-positive men in this study. The theory was used to understand how the HIV-positive men who were attached to two HIV agencies were coping with HIV. According to Lazarus and Folkman’s (1984) coping theory, the coping process begins with an appraisal, defined as the individual’s evaluation of the personal significance of a given event and his or her perception of the adequacy and availability of coping resources. A threat, harm, or challenge appraisal prompts coping. Coping is either emotion-focused (thoughts and behaviors a person uses to regulate distress) or problem-focused (managing the problem causing distress).

Lazarus and Folkman’s theory gave rise to the Concern and Coping with HIV (CCHIV) scale that was used in this study. The CCHIV categorized coping into nine factors: optimistic planning, involvement with the HIV community, social emotional support, spirituality, escape fantasies, self isolation, negative rumination, anger, and distancing. These factors are specific to the coping strategies among people living with HIV. Descriptive statistics of the coping scores from CCHIV show that individuals in this study utilize all kinds of coping strategies, some at a higher degree than others, but most importantly, they used all the types of coping strategies as categorized by the CCHIV scale. From the descriptive statistics, the participants in this study endorsed optimistic planning, involvement with the HIV community, social emotional support, and spirituality as the most likely coping strategies they use in coping with HIV. Lazarus and Folkman’s theory is not specific to stress associated with living with HIV. The limitation
of Lazarus and Folkman’s coping theory is partly because HIV/AIDS was not in existence when their theory was developed. However, Lazarus and Folkman’s coping theory was a useful theory from which the CCHIV was developed and has laid the ground work in which future coping theories can be created to include issues like coping with HIV, especially among Blacks and Latinos living with HIV/AIDS.

**Finding Three**

*Depression and overall coping:* A significant relationship between depression and overall coping strategies among the sample population was found. Specifically, significant relationships were found among three factors of coping: optimistic planning, spirituality, and anger. It is useful to understand the positive role of optimistic planning, spirituality, and anger in dealing with HIV. The relationship between spirituality and depression has been reported in the literature. According to the literature, there is evidence that African-American and Latino men use spirituality as a mediator for coping with HIV/AIDS. African-Americans’ reliance on spiritual coping at much higher rates than Whites has also been reported in a study by Bourjolly (1998).

The use of spiritual coping among HIV-positive persons has been previously reported in a study by Simoni and Ng (2000). The findings of this study further indicate that spirituality is an important coping strategy and highlights the need to include spirituality in programs that target African-American and Latino men living with HIV/AIDS. Faith-based programs that are broad based to include all belief systems can include spiritual beliefs in treatments. The therapist working with a client might inquire about the role of spiritual support in the client’s life. As suggested by Loue and Sajatovic (2006), it is recommended that: (1) a spirituality/religiosity component be included in
HIV-prevention programs to encourage people to seek spiritual support along with psychosocial support, which can be done in conjunction with faith-based programs that involve prayers and discourage homophobic attitudes by churches; and (2) incorporating spiritual beliefs into secular HIV-prevention efforts designed for African Americans and Latinos may be critical to the initiation and maintenance of risk reduction behaviors and the management of HIV infection among HIV-positive individuals. Therefore, spirituality among African-American and Latino men living with HIV/AIDS is a factor in coping with HIV as indicated from this study.

This study found that participants who used spiritual coping were less depressed; those who used optimistic planning were less depressed while those who were depressed were also angry. It is not surprising that those who were depressed were also angry. An HIV-positive individual may be angry because of the effects of living with HIV. The lack of immunity that makes the individual susceptible to any disease is a health concern. The frequent visits to the hospital and the amount of drugs that they have to take daily to manage HIV can contribute to anger in an HIV-positive individual. During the data collection at MAC, some of the men expressed their anger at their families and the church for the homophobic attitudes expressed towards them. One man in particular voiced his anger at his former church because he could no longer attend religious services there. According to him, the pastor and the church leaders were against gay people and preached openly against them. He expressed his frustration at his inability to attend religious services anymore but still considered himself spiritual.
Finding Four

Mode of HIV transmission and coping among Black and Latino men living with HIV: In this study, mode of HIV transmission was not related to coping. Coping strategy was not affected by the participants’ mode of transmission (sex, injection drug use, birth, and accident). It is possible that the level of stigma associated with this disease has reduced over the years, particularly in light of the fact that this disease affects both heterosexual and gay people. This study found that there were higher numbers of men living with HIV who are heterosexual than men who are bisexual or gay. Results from the year of diagnosis shows that 25% of the African-American and Latino men were diagnosed with HIV between 1984 and 1990. This means that some of the men have been living with HIV for more than 26 years. To these men, it may not matter how they were infected with HIV. It is possible that they are more concerned with other social factors like poverty, housing, and lack of healthcare, things that are critical to survival, than the mode of HIV transmission.

According to M. C. Zea (personal communication, February 2, 2010), Professor at the Psychology Department and the Director of the Latino Health Research Center (LHRC) at the George Washington University, Washington DC, “It definitely sounds as if Latinos under-reported being gay. Moreover, some segments of MSM do not consider themselves gay if they are "tops" (active), particularly those who come from rural areas of places where homosexuality is stigmatized.” She went further to state that “injection drug use is high in Puerto Rico; also, men who fear stigma of homosexuality may prefer to report infection through drug use than through sex with other men.” This report by a
well-known researcher on HIV/AIDS among Latinos means that Latino men may under-report their sexual orientation and therefore the mode of their HIV transmission.

**Finding Five**

*Mode of HIV transmission and depression among Black and Latino men living with HIV:* Findings from the mode of HIV transmission and depression also indicated that there was no relationship between mode of HIV transmission and depression. There was no relationship between how HIV was contracted and the levels of depression for African-American and Latino HIV-positive men. It is possible that these HIV-positive men are more concerned with other social issues than focusing on the mode of HIV transmission. As stated earlier, Johnston, Stall, and Smith (1995) reported that individuals who contracted HIV via homosexual sex or injection drug use (IDU) were less likely to receive support from their family members than from friends. Based on this finding, it was predicted that there would be a relationship between mode of HIV transmission and depression among Black and Latino HIV-positive men in this study. However, the implication of the finding in this study may indicate that the men in this study do not concern themselves about their mode of HIV transmission but on how to live with HIV.

The modes of HIV transmission can also be mixed as injection drug users are known to engage in high-risk sexual behaviors. According to the report by Oliver-Velez et al. (2003), injection drug users engage in unprotected sex in exchange for drugs or money. Some of the injection drug users also work as prostitutes and often do not use condoms with high paying clients. Injection drug use and high risk sexual behavior makes it difficult to determine the mode of transmission. However, both behaviors (high risk sex and injection drug use) present high risk for HIV infection, especially since most
of the individuals know they are HIV-positive and engage in the high risk behaviors anyway.

Summary of the socio-demographic data

One of the major contributions of this study was that it paid specific attention to African Americans and Latinos, populations that bear a major burden with regards to incidence and prevalence of HIV in the United States. According to the findings from this study, there was no significant difference in the levels of depression among African-American and Latino HIV-positive men. However, study findings from frequency distribution analysis indicate that African Americans and Latinos with minimal to mild depression composed 56% of the study participants. Eight percent of African Americans had moderate depression, compared to 32% of Latinos. Nineteen percent of African Americans had severe depression, compared to 8% of Latino men who had severe depression.

Age and Year diagnosed with HIV: The percentage of HIV-positive men (49%) between the age of 36 and 40 years who were diagnosed with HIV was higher than the percentage of HIV-positive men (12%) between the ages of 25 and 35 who were diagnosed with HIV in this study. The results indicated that there were more men in the 36-40 year old group than the 25-35 year old group.

Results from the year of diagnosis for the sample population indicated that 25% of the sample was diagnosed with HIV as early as 1984. It indicated that 25% of all the men have been living with HIV for the past 26 years. It is possible that taking Highly Active Antiretroviral Therapy (HAART) could have helped these men to live long with HIV. Discussion with this sample population during the collection of data revealed that
most of the men were taking the antiretroviral drugs. Specifically, 25% of the sample population was diagnosed with HIV from 1984-1990, 18% from 1991-1995, 30% from 1996-2000, and 27% were diagnosed with HIV from 2001-2008. The result shows that HIV is a serious concern among African American and Latino men in this study. It also indicates that African American men in this study continued to be infected with HIV from 1984 to 2008.

*Sexual orientation:* In this study, 40% of the African American men and 74% of the Latino men reported that they were straight/heterosexual, while 44% of the African American men and 13% of the Latino men reported that they were gay. Almost equal percentages of the African American men (12%) and Latino men (13%) reported that they were bisexual. Lesserman et al. (2000) and Perterson et al. (1996) reported that African-American gay men were less likely to seek social support, particularly from immediate family members. Although this could not be corroborated from the current analysis, some participants related their discomfort when discussing their HIV status with families of origin. In one of the group meetings with nine men, members narrated their level of discomfort in discussing their HIV status with their families. They also stated they found it difficult to disclose their sexual orientation for fear of being ostracized by their families. Disclosing their sexual orientation and HIV positive status might lead to lack of support from their families according to the group members. The research and clinical literature also suggests that African-American gay and bisexual men are less likely than White men to be open about their sexuality with their primary support network. According to Ostrow (1991), African-American gay and bisexual men report that their support networks are less supportive than those of White men.
Wright (1993) found that some African-American men are heterosexuals who engage in sex with men to satisfy their sexual or economic needs. This type of sexual behavior has been described as “men on the down low” (Wolitski, Jones, & Wasserman, 2006). Wolitski, Jones, and Wasserman (2006) indicated that these MSM are typically characterized as: (1) Black, (2) not identifying as gay, (3) having sex with both men and women, (4) not disclosing their sexual behavior with men to female partners, and (5) never, or inconsistently, using condoms with males and females.

The danger of not disclosing sexual orientation could lead to men having sex with both men and women and spreading HIV to their unsuspecting partners. According to Millet et al. (2006), late diagnosis of HIV, especially among African Americans, could explain the high prevalence of HIV among this population. Late diagnosis means that HIV positive men could transmit the infection to other individuals even before they know that they are infected.

Living arrangement: A high percentage (62%) of the African-American and Latino HIV-positive men in this study indicated that they were living alone. Specifically, 64% of the African-Americans and 61% of the Latinos were living by themselves. Living with HIV makes it more important that the individual would need support from loved ones in the form of friends and family. The fact that most of these men were living alone could explain the desire to seek psychosocial support from agencies like BLC and MAC. There were a low percentage of the men living with a partner/wife. For the African-Americans, 8% were living with a partner/wife and 11% of Latino men in this study indicated that they were living with a partner/wife. Twenty-four percent of African-American and 21% of Latino HIV-positive men indicated that they were living with
friends or relatives. Individuals like these have clothes scattered all over the place and most of the time are not sure where they will spend the night. This type of uncertainty is unsettling, and 22% of the African-American and Latino HIV-positive men in this study found themselves in this situation. A participant in the study described himself as homeless because he did not have a house of his own, but moved from place to place. He stated that his situation was even worse because he was Black, gay, HIV-positive, and isolated by his family. He moved from one friend to another without the option of going to family members. Again, one patient in clinical practice described himself as homeless even though he stayed with friends and relatives. According to him, he was treated as a nuisance because he did not pay rent and was not given the key to the house. He had to wait to make sure that someone was in the house before he could go in. He felt uncomfortable staying in a friend’s house for too long and had to move somewhere before they made him feel unwanted. He was also asked to contribute to the rent in some cases when he did not have the money to pay. When he stayed with friends and relatives, he slept on the couch and had to wake up early and leave the house. He summarized that he was basically homeless, just like someone in a shelter. The concern here is that HIV-positive individuals need a stable housing arrangement.

**Place of Residence:** Sixty-eight percent of the men in this study were living independently, with 31% living in a group home, which includes shelters and residential halls. Shelters provide a bed at night and are on a first come first serve basis. Individuals do not have a guarantee of a bed unless they make it on time in the evening to secure a bed. Most HIV-positive individuals are taking antiretroviral drugs that help them manage
their infection. Living in unstable housing does not give peace of mind and may also interfere with medication adherence.

**Marital Status:** In this study sample, 76% of the African-American and 50% of the Latino HIV-positive men were never married. Only 8% of the African-American and Latino HIV-positive men were married. The number of unmarried men was high, considering that the population was composed of men between the ages of 25 and 62 years, an age range in which most people are married. The high number of unmarried men could also explain why there were a high percentage of the men living independently.

**Unemployment:** This study also revealed the extremely high level of unemployment among this population of HIV-positive African-American and Latino men. More than 84% of all the men were unemployed. According to the records from Massachusetts, Boston’s unemployment rate for the entire population was 8.3% at the end of December 2009 (U.S. Bureau of Labor Statistics, 2010). The disparity in the unemployment rate between Boston and the HIV-positive men in this study is high in view of the fact that this study was conducted in Boston. The neighboring towns to Boston recorded different rates of unemployment compared to Boston. For example, the town of Chelsea had an unemployment rate of 10.9% as of December 2009, and the city of Lawrence’s unemployment rate was 17.8% as of December 2009. The recent economic crisis in the United States has made it even more difficult for these men to get jobs since most organizations are not hiring. People living with HIV continue to deal with the stigma and discrimination typically associated with HIV/AIDS (Hergenrather et al., 2006). According to Werth et al. (2008), HIV is now considered to be a chronic illness
for many people. The report went further to state that workplace discrimination is a potential problem that could affect an HIV-positive person seeking or holding a job. Stigma and workplace discrimination may have a relationship with an HIV-positive person’s attitude to work and can also explain the high rate of unemployment among the participants in this study. According to Arns, Martins, and Chernoff (2004), the Americans with Disability Act (ADA) and court decisions have emphasized that a person with HIV is considered to have a disability that is covered by the act. Some of the men reported from the group discussion that they were receiving social security disability assistance or some form of support from the government and HIV/AIDS agencies. These supports include: low cost housing; food stamps; and daily hot meals, like the ones provided by Boston Living Center for its members. The high level of unemployed participants in this study could also be a result of non-participation of employed HIV-positive men who are working and therefore not available to utilize the services of MAC and BLC. Another explanation for the high rate of unemployment among the sample could also be found in Zea et al. (2005). Their study stated that disclosure of HIV-positive serostatus results in harmful reactions as extreme as physical assault or loss of employment.

Similarly, the Center for Disease Control (2009) identified unemployment as among the socioeconomic factors that Latinos face living with HIV/AIDS. Unemployment and lack of money will also affect the levels of care and support that these men are able to provide to their children. Research on the relationship between unemployment and HIV is limited and not specific to African Americans and Latinos. “The proportion of HIV-infected people who continue to work without interruption or
alteration in hours is unclear (Rabkin et al., 2004, p.72). The study further stated that the benefits of employment may be reduced or terminated for people receiving expensive medication who are no longer considered disabled by HIV illness. Hergenrather, Rhodes, and Clark (2006) have reported the importance of employment among people living with HIV/AIDS. The study highlighted the relationship between employment and improved functional status and quality of life, and as a measure of monitoring HIV prognosis. They went further to state that employment has significance in successful living and emotional well being among people living with HIV/AIDS.

The high rate of unemployment among the study participants is of huge concern. Having a job could boost an individual’s self esteem and provide much-needed financial resources to care for basic needs. According to Brown and Sankar (1998) and Whitehead (1997), African-American men with HIV contend with stigma associated with their illness, but they are also exposed to racial discrimination, higher rates of unemployment, and disparity in access to care.

**Study Limitations**

While this study provides important findings regarding HIV-positive Black and Latino men in the Northeast, there are several study limitations. One of the limitations of this study was the small sample size. This study utilized a convenience sample of Black and Latino men only. The sample size was limited to 64 participants, although a total of 76 protocols were collected; twelve were excluded based on not meeting the inclusion criteria (adult male, African American, or Latino). One other limitation of this study was its restriction to men only. Experience has shown that the participants in this study required incentives to participate in the study; this required more resources than this
investigator could afford. The study specifically sought to understand the experiences of African Americans and Latinos. However, HIV-positive individuals from other ethnic groups who wanted to participate in the study felt excluded. In its focus solely on African Americans and Latinos, this study was limited. Given the high numbers of Black and Latino men who have immigration histories, particularly in the Northeast, this work did not isolate race from immigrant status.

Another limitation was the restriction of participants to individuals who were linked to agencies that provided HIV services. This could have had an impact on the high number of unemployed men in this study. Most of these men did not have jobs and therefore found those places as useful resource centers.

Finally, this study was not a mixed methods investigation and thus there was no emphasis on qualitative data gathering. Focus groups or semi-structured interviews would have been helpful in identifying themes that quantitative research is simply unable to capture.

Implications for Policy, Future Research, and Clinical Practice

The findings of this study have many implications for research, and clinical practice. The most important finding in this study was the accomplishing of the purpose of the study, which was to identify coping strategies and the levels of depression among the participants. Analysis from the study indicated that spirituality, involvement with the HIV community, and planning are important coping strategies that this population utilizes.
Figure 2 below presents a summary of the implications of this study.

Figure 2. Implications

**Future Research:** Future research should explore the correlation between levels of education and employment to see if there is any relationship between the two among HIV-positive individuals.

Future research to involve HIV positive men and women who are linked to services and those who are not.

**Policy:** Promotion of safe sex and distribution of condoms to continue. Consider men on the “down low” in prevention programs.

Promote programs that put men back to work and include cultural values of people of color that are living with HIV.

Prevention programs to target new ways of delivering HIV prevention messages to African American and Latino gay and bisexual men and their communities.

**Clinical Practice:** Clinicians need to understand the importance of referring clients to agencies that offer psychosocial services to HIV-positive individuals.

The willingness of clinicians to incorporate the spiritual values of clients into their treatment plan if they are relevant to the client.

Referral to a case manager will help clients find solutions to their social needs, like employment, housing, transportation, access to health care, and adherence to medication.
This study also suggests the inclusion of these factors in the design and implementation of HIV programs, specifically for African Americans and Latinos. The inclusion of literature in English and Spanish needs to continue for those Latino men and women who do not understand or read English. The findings also highlighted the major roles of the sites that provided psychosocial services for HIV-positive individuals. These agencies provided the much-needed social support, a sense of belonging, and sharing that help with the alleviation of the stress associated with living with HIV.

Policy: It is important to include programs and policies that address the cultural values of minorities that are diagnosed with HIV. Brooks et al. (2005) indicated that HIV-related stigma and discrimination are among the greatest impediments to local efforts to combat HIV disease. “Prevention programs must explore new modalities and venues for delivering HIV prevention messages that are appropriate for Latino and African American gay and bisexual men and the communities in which they live” (Brook et al., 2005, p. 740). A finding from this study indicates that 60% of HIV-positive Latino men had children. The large percentage of HIV-positive Latino men with children has implications for the incidence rate of HIV. Poor education policies on HIV prevention could lead to higher rates of children born with HIV, which could be prevented. Prevention from mother-to-child programs should continue to be promoted, and disclosure of HIV to partners should also be encouraged through billboards and TV advertisements. Findings from this study also indicated that more Black men contracted HIV though sex than Latinos, who had higher rates of HIV infection through injection drug use. The clean needle exchange programs that are offered in some healthcare agencies can be an effective prevention program for HIV transmission. Safer sex
programs and the distribution of condoms offer poor people access to protection and birth control. Prevention agencies like the Multicultural AIDS Coalition should expand existing programs for men having sex with men (MSM) to include efforts to reach “down low” MSM clients.

**Implications for future research:** In this study anger, spirituality, and optimistic planning were correlated with depression. Future studies should be open to HIV-positive individuals who are both involved with services and those who are not connected to services for better comparison of findings. One of the reasons why this study was limited to participants who were involved with services was the opportunity to provide follow up services, should the need arise. For example, due to the vulnerable nature of this population, it was necessary to follow up with a participant who expressed suicidal ideation. Arrangements were made with MAC and BLC for follow-up. Future studies that are open to participants who are not involved with any agency like MAC and BLC should make provisions for mental health services for all its participants should the need arise. This will make it easy to follow up with a participant who may be in crisis during the study.

Future research might include women who are HIV positive, whether they are linked with an agency or not. There was also the initial thought of including a qualitative piece to this study; this can be included in a future study. Further research should also investigate the low literacy levels and employment rates among African-American and Latino men who are HIV positive. Future research might explore the relationship among levels of education, race, employment, and HIV-positive status. Although African-American men in this study had higher levels of education than Latinos, they still
presented with higher levels of unemployment. Future research should differentiate between Latinos and African-Americans who are born in the United States and those who immigrated to the United States.

**Implication for clinical practice:** The findings from this study also have implications for clinical practice. The clinician attending to an HIV-positive African-American or Latino man needs to understand the importance of referring this client to agencies that offer psychosocial services to HIV-positive individuals. The clinician also needs to incorporate the spiritual values of clients into their treatment plan if they are relevant to the client. The objective would be to encourage spiritual involvement and participation. Referral to a case manager will also help the client find solutions to their social needs, like employment, housing, transportation, access to health care, and adherence to medication.

This current study has attempted to look at the relationship between depression and coping among Black and Latino HIV-positive men, and it has presented some important findings. This study also suggests more questions - for example, the need to look at specific variables with this population, like the high unemployment rate among HIV-positive men. Additional research in this area would be important in developing psychosocial programs that would assist this population that is in great need. This author would recommend replicating this study on a larger scale and including participants who are linked to agencies and those who are not.
References


among Latino and African American gay and bisexual men in a context of HIV-
related stigma, discrimination, and homophobia: perspectives of providers. *AIDS
patients care STDS, 19*(11), 737-744.

Aging, 20*(6), 865-884.

Lymphocyte decline among HIV-infected men. *Journal of the American Medical
Association, 270*, 2568-2573.

267–283.

Carrico, A. W., Ironson, G., Antoni, M. H., Lechner, S. C., Duran, R. E., Kumar, M., &
symptoms and 24-h urinary-free cortisol in HIV-positive persons. *Journal of
Psychosomatic research. 61*, 51-58.

anxiety: Help-seeking and social support among gay men with various HIV
diagnoses. *AIDS, 6*, 999–1005.


Appendixes

Appendix A: Concern And Coping With HIV Scales (CCHIV)

**Responses**

Even when people might be feeling the same kind of stress, they may respond very differently. Please circle a number for each item to show how you cope with your HIV/AIDS infection. Please show what you actually did/do, not what you think you should have done.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all</th>
<th>Some</th>
<th>Very often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Tried to figure out who gave you the virus</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>Turned to work to take your mind off things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>Stood your ground and fought for what you wanted.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4.</td>
<td>Blamed others for what they did.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5.</td>
<td>Let your feelings out somehow.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.</td>
<td>Thought about others you know who are HIV positive.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7.</td>
<td>Avoided making new relationships.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8.</td>
<td>Felt like a victim of fate.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9.</td>
<td>Explored your spirituality more deeply.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10.</td>
<td>Attended groups for HIV-infected people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11.</td>
<td>Worked out, jogged, or exercised.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>12.</td>
<td>Stayed around people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13.</td>
<td>Began or resumed individual counseling.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14.</td>
<td>Thought about killing yourself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15.</td>
<td>Tried to kill yourself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>16.</td>
<td>Learned about and used safer sex techniques.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td>Some</td>
<td>Very often</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------</td>
<td>------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>17. Told yourself things that helped you feel better.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Wrote about your feelings in a diary or journal.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Felt numb and shut down emotionally.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Did not let it get to you: refused to think about it too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Decided to go out and have some fun.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Called your therapist to talk about your feelings.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Distracted yourself with other activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Found new faith.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. Made a plan of action and followed it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. Expressed anger to the person(s) who caused the problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Tried to forget the whole thing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. Regretted some action that you took.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. Worked with groups to help people sick with AIDS.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30. Changed or grew as a person in a good way.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31. Wished the situation would go away or somehow be over with.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32. Asked a relative or friend you respected for advice.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33. Abstained from sex.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34. Tried to keep your feelings to yourself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35. Talked to someone about how you were feeling.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>36. Made light of the situation: refused to get too serious</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>Depression and Coping with HIV</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>about it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Tried to rediscover what is important in life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38. Hoped a miracle would happen.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39. Accepted sympathy and understanding from someone.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>40. Kept others from knowing how bad things were.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>41. Realized you brought the problem on yourself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>42. Prayed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>43. Got away from it as best you could.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44. Had fantasies about how things might turn out.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45. Reminded yourself how much worse things could be.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46. Stayed home more.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47. Went on as if nothing was happening.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>48. Asked someone to help you do something about the problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>49. Tried to make someone else treat you differently.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>50. Used drugs (not prescribed by your doctor) or alcohol.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>51. &quot;Laid down the law&quot; to someone about something.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>52. Other (specify):</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendixes B: Informed Consent Form

Northeastern University: Department of Counseling and Applied Educational Psychology
Cyril Ubiem, M.A.: Tracy Robinson-Wood, Ed.D.
Title of Research: The relationship between depression and coping among Black and Latino men living with HIV/AIDS

Informed Consent to Participate in a Research Study
You are invited to participate in this research study. This form will tell about the study but feel free to ask me any question that you have. When you are ready to make a decision, you can tell me if you want to participate or not. You do not have to participate if you do not want to. If you decide to participate, I will ask you to sign this statement and will give you a copy to keep.

Why am I being asked to take part in this research study?
We are asking you to take part in this study because you are a HIV positive male of either Latino or African American ethnic group. This is the main population required for this research.

Why are you doing this research study?
The purpose of this study is to identify the levels of depression and the coping strategies that this population utilizes. This information will be helpful for others to use.

What will I be asked to do?
If you decide to take part in this study, we will ask you to fill a short demographic form, a coping strategy form, and the BDI-II which is used to assess the severity of depression. The three forms should take you approximately 25 minutes to complete. You will be interviewed at your location at a time that is convenient for you.

Will there be any risk or discomfort to me?
You may experience some symptoms of stress and anxiety as you think about the responses to the questionnaires. These symptoms include worry about your HIV status and anxiety about the future. It might be discomforting for you to talk about your HIV status. If these symptoms become disturbing to you, please contact the counseling department at Multicultural Aids Coalition on (617) 238 2404 or the Victory Programs, Inc. (LARC program on 1617-522-2936 x 23

Will I benefit from the study?
There will be no direct benefit to you for taking part in this research. However, the information learned from this research will help us to understand the relationship between HIV/AIDS and depression and better ways of coping with HIV/AIDS.

Who will see the information about me?
The forms have been coded with numbers to protect your confidentiality. After signing the consent forms, it will be separated from the other forms and locked in a cabinet. Only the coded forms will be used for further analysis. My advisor, Dr. Tracy L. Robinson-
Wood and I will be the only people who will see the forms and scales. Your part in this study will be confidential. No reports or publications will use information that can identify you in any way.

Ethically we are required by law to report any threat to one’s life or others. If you tell us that you will kill yourself or someone else, we are required to report such information to the authorities for further action.

In rare instances, authorized people may request to see research information about you and other people in the study. This is only to be sure that the research is done properly. We would only permit people who are authorized by organizations such as Northeastern University to see this information.

**Can I stop my participation in this study?**
Your participation in this research is completely voluntary. You do not have to participate if you do not want to. You can choose not to participate at any time. Feel free to ask me any question that you may have.

**Who can I contact if I have questions or problems?**
You can call Cyril Ubiem on (617)412-1794 or my advisor, Dr Tracy Robinson-Wood on (617)373-5936 for any questions or problems.

**Who can I contact about my rights as a participant?**
If you have any concerns about this research, you may contact Nan Regina. She is the Coordinator for Human Subject Research with the Division of Research Integrity at Northeastern University. Her address is 413 Lake Hall, 360 Huntington Avenue, Boston, MA 02115. Her telephone number is (617) 373-7570. Her fax number is (617) 373-4595. You may call anonymously if you wish.

**Will I be paid for my participation?**
Upon completion of the three questionnaires, you will receive a $10 gift card to Dunkin Donut for your participation.

**Is there anything else I need to know?**
You must be at least 18 years old to participate in this research.

Signature of person agreeing to take part     Date

Printed name of person above

Signature of Researcher     Date

Name of Researcher
Appendix C: Demographic Form

The Robinson Resistance Modality Inventory Demographic Sheet

Instructions: Please answer all questions carefully and honestly. Your responses will be kept confidential and they will not be shared with anyone. I greatly appreciate your time and willingness to participate.

1. I am ________ years old
2. I am _____male  ____ female
3. My ethnicity is (Check one). For example, place a √ next to the appropriate response
   ___ African American ___Black ____Biracial/Multiracial ________________ Other
4. My highest education level is (check one)
   ___ High School Graduate     ___ Some College (not enrolled in college now)
   ___ Currently enrolled in College     ___ Associate of Arts degree
   ___ B.A. or B.S. degree     ___ Currently enrolled in graduate school
   ___ M.A., M.S., or Ed.M. degree     ___ E.D.D., J.D., M.D., Ph.D., Psy.D., Pharm. D
   ___ Other (please explain)_____________________________
5. I am employed ___No  __Yes (if yes) __ part-time __Full time. Weekly income $___
6. I am (Check one)
   ___ Never married ____Married ___Divorced ___ Separated ___ Widowed
7. I live in (Check one)
   ___ A Residential hall ____A Shelter ____ A group home ____ An Apartment/house
8. I live (Check one)
   ___ Alone   _____With my parent  _____With my foster parents
   ___ With friends and/or relatives   _____With my partner or husband
   ___ Other (Please specify) _______________________________________________
9. I am (Check one)
   ___ Agnostic ____ Atheist    ____Buddhist        ____Christian   ____Muslim
   ___ Other (Please specify)_______________________________________________
10. (Check one)
    ___ I do not have children       ___ I have children (please indicate how many) __
11. My sexual orientation is (Please check one)
    ___ Bi-sexual ___Straight ___ Gay ___Other (specify) _______________________
12. I got HIV from (Check one)
    ___ Sex   ____ Blood transfusion ___ Injection drug use ___ Birth ___ Accident
    Other (Please specify) ___________________________________________________
13. I was diagnosed with HIV in (Indicate year) ____________________________
Appendix D: Permission Letter from MAC

Multicultural AIDS Coalition
31 Heath Street, Suite 12
Jamaica Plain, MA 02130
Tel. (617) 442-1622, Fax (617) 442-6622
Website: www.mac-boston.org

December 18, 2007

Department of Counseling and Applied Educational Psychology
Northeastern University Boston
360 Huntington Avenue, 02125, MA

Dear Cyril Ubiem,

We are pleased you’re interested in learning more about the needs and coping skills of Black and Hispanic HIV infected men. The Multicultural AIDS Coalition supports meaningful and relevant community research. Established in 1988, MAC is a valued community resource for the dissemination of information about HIV, supporting people living with HIV, and forging strong partnerships with community and educational institutions to maximize access to a wide array of support services.

The MAC is proud to be one of the sites you selected to help inform your dissertation. The data you collect will also help us to improve services to this population. We will allow you to conduct surveys at our site, with the informed consent of our clients.

I have included an agency profile and my contact information should you require additional information please feel free to call. Again, thank you for meaningful community-based research you conduct.

Sincerely,

Cynthia Harris
Program Director
Appendix E: Permission Letter from Boston Living Center

December 18th, 2007

To Whom It May Concern:

This letter is to verify that Cyril Ubiem, PhD. Student at Northeastern University, has permission from our agency to include our membership in his research on men coping with HIV and depression. He will be administering his survey here onsite in the winter of 2008.

Feel free to contact me with any questions at (617) 236-1012 x229.

Sincerely,

Julie Barnes, M.A.
Director of Member Services

Boston Living Center
29 Stanhope St.
Boston, MA. 02116