



## **HARDINESS EDUCATION NEEDS AFTER AIDS PARENTAL LOSS: A PHENOMENOLOGICAL STUDY IN NIGERIA**

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### **ABSTRACT**

Inseparability of human life and stress calls for increasing need for practical coping strategies to ease life's unforeseen contingencies. Loss due to AIDS carries unique ramifications that complicates coping and thus challenge historical models of bereavement. Sub-Saharan Africa is home to ninety percent of AIDS orphans and Nigeria contributes almost 2.5 million of these orphans. Providing care and support for them constitute continuing challenge to healthcare delivery system. The study recruited six unsupported AIDS orphaned youths between the ages of 18-24 years purposively and collected data through in-depth semi-structured interviews. Transcribed interviews were analyzed using Colaizzi seven steps of analysis to derive themes. Main themes relating to hardiness were presented and discussed in relation to the hardiness theoretical framework. The findings of the study reveals that opportunity for hardiness education exists in the participants and this should be taken advantage of by health professionals and educators alike.

**Keywords:** Hardiness; AIDS orphanhood; Nigeria; Coping

### **Introduction**

Nigeria is geographically a Western African country and also part of the larger sub-Saharan Africa (SSA) region. It is the most populous African country and is rated seventh in the world with an estimated population of 173 615 000 (United Nations [UN], 2006). Nigeria's population has been projected to surpass that of the United States of America by 2050, probably making it the fourth populous country in the world (UN, 2006). The country is organized into 36 states and the Federal Capital Territory (FCT). The states are further divided into 774 local governments (National Agency for the Control of HIV/AIDS [NACA], 2012).

Just like any other country of the world, Nigeria has equally been tremendously affected by the HIV and AIDS pandemic. Worldwide, Nigeria has the second highest number of new HIV infections estimated at 310 000, second only to South Africa whose new HIV infections were estimated at 610 000 (UNAIDS, 2013). The HIV prevalence of 4.1 percent in Nigeria might seem low when compared to other African countries such as South Africa (17.3 percent) and Uganda (7.2 percent), however the continued expansive population estimated above 162 million meant that by the end of 2011, there were an estimated 3 400 000 people living with HIV (AVERT, 2013). These statistics mean that Nigeria carries the second heaviest burden of HIV and AIDS in the world (AVERT, 2012). The HIV epidemic in Nigeria is generalized but with wide variations of prevalence within the country (NACA, 2012). The states with the highest HIV prevalence are Benue (12.7%), Akwa Ibom (10.9%) and Bayelsa (9.1%); however the highest site prevalence of 21.3% was reported from Wannune in Benue State (NACA, 2012).



## **Background**

The HIV and AIDS epidemic has affected every country of the world and current statistics on HIV/AIDS reveals that 34 million people are living with HIV worldwide (UNAIDS, 2013). Sub-Saharan Africa has been disproportionately affected by the HIV epidemic, as it is home to 23.5 million of the total estimated number of people living with HIV/AIDS (AVERT, 2012; UNAIDS, 2013). In a region that only accounts for 10% of the total world population, housing two-thirds of the 34 million HIV positives means the region is the epicenter of the epidemic (UNAIDS, 2013).

One of the impacts of HIV epidemic is the emerging and massive cohort of AIDS orphans and other vulnerable children. During the 30 years of the global HIV epidemic, an estimated 17 million children have lost one or both parents to AIDS, 90% of these children live in SSA (UNAIDS, 2013). Several authors (International Labour Office, 2006; UNICEF, 2010 and Woodring, Cancelli, Ponterotto & Keitel, 2005) have projected that, should the spread of HIV stop today, the numbers of AIDS orphans will continue to increase or at least remain significantly high for years to come owing to the time lag that exists between parents' infection with HIV and death from AIDS associated causes. Providing effective care for AIDS orphans have thus constituted one of the biggest challenges to health care system in Africa

The AIDS epidemic in Africa puts young people at risk physically, emotionally and economically. One of the ways by which HIV and AIDS affects young people is through the loss of one or both parents to AIDS related illness. Doku (2009) suggested that parental death regardless of its cause place survivors under heightened risk for problems such as depression, anxiety, loss of opportunities, hardships and loss of parental guidance. The pervasive influence of stigma and discrimination attached to HIV epidemic can therefore predict worse outcomes for young people whose parental loss is attributed to AIDS.

In Nigeria, 2.4 million young people are orphaned due to AIDS (FMWASD, 2008). New infections have stabilized, but owing to a time lag between parents' infections and death, adults death will continue to add to the number of AIDS orphans in the next decade (AVERT, 2012). Even with improved effectiveness, ease of administration and access to treatment, the number of AIDS orphans will thus remain exceedingly high (UNICEF, 2012). Ongoing prevention strategies must thus be joined by efforts to improve the quality of life for all who are and will continue to live with and be affected by HIV and AIDS in Nigeria. According to PEPFAR (2012), programming for children and youths affected by HIV/AIDS contributes to achievement of an AIDS free generation and calls for appropriate responses to the social and emotional consequences of the disease on them. Furthermore UNICEF (2010) and FMWASD (2008) also recommends that interventions for these youths should reflect local realities and should incorporate the unique experience of individual affected youths so that HIV-sensitive care can be rendered.

Loss due to AIDS carries unique ramification that complicates adjustment and coping (Sikkema, Kalichman, Hoffman, Koob, Kelly & Heckman, 2000). This is because it is complicated by a set of material and psychosocial stressors that accompanies parental death (Lauren, 2001) and thus challenges historical models of bereavement (Kain, 1997). Parental failing health and eventual death to AIDS means young people face a unique crisis of losing parental love, guidance, stability and support, as well as risk of losing the link with the past and the possibility of a shared future (Wild, 2001). These might be connected to pervasive influence of stigma, discrimination, loss of resources and chronicity of the infection that terminates to death. The experience of losing a parent to AIDS can be imagined to be far worse for youths who need the presence of their parents to carve out a secure



future and are also faced with challenges accompanying transition to adulthood and forming an identity.

However, international and local development discourses/interventions (PEPFAR, UNICEF, FMWASD) does not regard AIDS orphans as requiring support and assistance after reaching the threshold of eighteen years. The exclusion of young people over eighteen years from support is thus unbelievable considering that the prevalence of AIDS orphans increases with their age (Family Health International, 2009) and they must have grown into youths by the time of parental death because of the time lag of HIV infection. This suggests that youths AIDS orphans above the age of eighteen years must find a means of coping with their situation. Parental loss represents an ongoing set of stressors that constitute a threat to healthy social development of AIDS youth orphans and increase their vulnerability to HIV infection and abuse of various types due to economic needs and loss of parental shield. Several studies (Skovdal & Ogutu, 2009; Cluver & Gardner, 2007; Kuo & Operario, 2009; Walker, 2002; Harms, Jack, Ssebunya & Kizza, 2010;) have thus been advocating for coping skills among AIDS orphans.

The concepts of resiliency and hardiness have somewhat been used interchangeably in the literature to explain how an individual may bend but not break under the pressure of stressful and traumatic events. Over the years, both the concepts of resiliency and hardiness have evolved in definitions, attributes, defining characteristics and specific sources; but it is important to note that they are not the same. Resilience is understood as referring to positive adaptation, or the ability to maintain or regain mental health, despite experiencing adversity (Herrman, Stewart, Diaz-Granados, Berger, Jackson & Yuen, 2011). A variety of personal or dispositional resources contribute to individual's resiliency. Hardiness, widely used in the medical, military and sports context, captures specific individual characteristics helpful to overcome and deal with negative life events (Maddi, 2006).

Considering that youth is a distinct life stage that is bound to have its specific health needs, developmental tasks and specific social responsibilities and expectations; majority will agree that parental loss at this stage is not only devastating but disruptive and life-defining. It is not that hardy people do not suffer trauma or distress but Kobasa (1979) assert that hardy people transforms their difficulties into productive outcomes by using personal resource of control, commitment and challenge to combat negative life events. This phenomenological study explored the opportunities for hardiness education and the question asked is: what hardiness factors do youths employ in meeting their needs after parental AIDS loss?

## **Theoretical framework**

The theoretical framework guiding this study stems from the work of Maddi & Kobasa (1984), which was termed 'Factors Affecting Health/Illness Status'. Within this framework, all stress generating events represent potential strains or threats to individuals. For an individual, a continuous stress can represent a menace or tension, which may manifest physically (trembling, chest pain, headache) or psychologically (anxiety, depression, loss of interest in self and life). Those facing continuous and repetitive stress such as AIDS parental loss may show decreased resistance to stress, leading to physical or psychological strain. Maddi & Kobasa (1984) stipulate that to confront stressful events, hardy individuals examine the situation in perspective and perceive them as meaningful (commitment) but changeable (control) and of potential value for personal for personal growth (challenge). This framework suggests that hardiness not only buffers against the deleterious effects of stressful life events but also sensitizes an individual to the type of social support someone would use in times of



stress. Hardy coping however can be said to occur only when an individual displays the attributes of commitment, control and challenge in a particular situation.

## **Literature review**

Inseparability of human life and stress calls for increasing need for practical coping strategies to ease life's unforeseen contingencies. Outstanding evidence abounds on the direct causal relationship between stress and illness development (Alfred, 2011; Maddi, 2007; Bartone, Hystad, Eid & Brevik, 2012; Kobasa, 1979, Wadey, Evans, Hanton & Neil, 2012). The original use of the word 'hardiness' was formally used in agriculture and it denotes the survival abilities of plants in adverse growing conditions (Lee, 1982). However, Kobasa (1979) first introduced 'hardiness' into the literature after her study of business executives coping and attitudes to illness provoking stressors. Kobasa (1979) defined hardiness as an aspect of personality that buffers the effects of stress on health and conceptualized it as consisting of three attitudes of commitment, control, and challenge (3Cs). Although several authors (Funk & Houston, 1987; Brooks, 2003; Eschleman, Bowling & Alarcron, 2010) have expanded, critiqued and conducted meta-analytic review; the three components of hardiness initially conceptualized by Kobasa (1979) has not been altered up till date.

Hardiness has been discussed along the path of positive psychology, with researchers favoring it as the basis of existential psychology (Alfred, 2011; Maddi, 2007). Existential psychologists believe that individuals must continually make decisions in an inherently stressful environment. Rather than shrinking towards the past using such traits as denial and avoidance, an individual should be future oriented; by facing challenges and learning from it for personal development (Maddi, 2007). Since the initial introduction of hardiness by Kobasa (1979), research studies with different population and using different research methodologies have demonstrated that hardiness appears to prevent stress and enhances healthy performance (Simoni & Paterson, 1997; Gironda, Der-Martirosian, Abrego, Black, Leathers & Atchison, 2006; Kuo & Tsai, 1987; Eschleman et al., 2010; Maddi, 2014; Bartone et al., 2012). The usefulness of hardiness personality has been demonstrated in the field of sport, psychology, nursing and most often and recently in the art of military training.

The current body of literature relating to the phenomenon of AIDS orphanhood has been increasing significantly over the past two decades. The various types of quantitative studies conducted over the years have resulted in taxonomies capturing the magnitude of AIDS orphans worldwide (UNICEF, 2012, UNICEF, 2006, PEPFAR, 2012). Epidemiological studies have also revealed living and caregiving arrangements for orphans (Skovdal & Ogutu, 2009; Evans, 2010). Additional studies are reporting on the academic, physical, social and mental outcomes of AIDS orphans (Doku, 2009; Nyakumapa, Gregson, Lopman, Saito, Watts, Monasch & Jukes, 2008). Emerging studies are recently focusing on orphans experiences and the outcomes of interventions to be able to render more sensitive care (Harms et al., 2010; Thurman, Snider, Boris, Kalisa, Nyirazinoye & Brown, 2008). However, despite that AIDS orphans are not necessarily children; no specific programs is available for AIDS orphans as they transition into eighteen years in Nigeria, despite that they need more assistance for education and skills training which are more expensive and less affordable (Centre for Global Health and Development, 2009).

There exists limited research that specifically focus on AIDS orphans above the age of eighteen years and this suggests that little information exists on their needs and coping needs in Nigeria. Cluver, Orkin, Gardner and Boyes (2012) conducted a longitudinal study among AIDS orphans between the ages of 12-23 years in South Africa. The study sought to determine persisting mental health challenges among orphans and found that the impact of AIDS-orphanhood gets worse not better, with time and



with the developmental process of growing up. Cluver et al., (2012) reported that age interacted with AIDS-orphanhood status to magnify the rise in levels of depression, anxiety and Post Traumatic Stress Disease (PTSD). This suggests that negative mental health outcomes were maintained and worsen after four years despite that the orphans are now youths and no longer children. Evans (2010) used a mixed-method approach to explore the experiences and support needs of AIDS orphans aged 12-23 years who are house-hold heads in Uganda and Tanzania. The study reveals that older orphans face untold hardship because they become household heads after parental death and Evans (2010) went on to criticize the strict age-based definition of AIDS orphans and their eligibility for support. Other studies conducted in other parts of SSA and around the world reveals that AIDS orphans are at risk of heightened emotional and behavioural disorders in Ghana (Doku, 2009); more emotional problems, negative life events and contact with criminal justice system than non-AIDS orphans in the USA (Rotheram-Borus, Weiss, Alba & Lester, 2006); adjustment problems, internalizing problems and stigma was rife among AIDS orphans in China (Zhao, Li, Zhao, Zhang and Stanton, 2012). This makes the researchers ask, how can the AIDS orphans of a certain age, without government support in Nigeria cope with uncertainties facing their future?

## **Methods and Procedures**

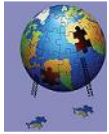
The research question guiding this phenomenological study is: what hardiness factors do youths employ in meeting their needs after parental AIDS loss? The study was granted ethical clearance by both Benue State Teaching Hospital (BSTH) and the Biomedical Research Ethics Committee of the University of Kwazulu-Natal (UKZN). Pseudonyms were used to protect the identity of participants and all participants completed informed consent forms.

## **Study population and setting**

The study was conducted in Wannue town. Wannune was chosen because of its high HIV prevalence, estimated at 21.3%, the highest in Nigeria. Wannune is the administrative headquarters of Tarka local government, which is one of the 23 local governments in Benue state, Nigeria (National Population Commission [NPC], 2007). Wannune is a small town with an area of 371 km<sup>2</sup> and a population of 79 494, based on the census of 2006 (NPC, 2007). Tarka LGA of Benue state is situated in a rural setting and the major occupation of the people is farming, with only a few employed in white collar jobs (Goon, Toriola, Uever, Wuam & Toriola, 2010). The predominant ethnic group in the town is the Tivs and they speak Tiv language, Christianity is also the predominant religion in the town. The only secondary health facility in the town is General Hospital Wannune (GHW) and it currently provides antiretroviral therapy (ART) services for about 4, 000 HIV infected adults and 200 infected children (Goon *et al.*, 2010). The target population for the study was youths between the ages of 18-24 years who have lost a parent to AIDS related illnesses. The inclusion criteria for study participation were: ability to give verbal autopsy; orphaned for more than a year (to preserve grieving process and minimize psychological trauma); aged between 18 to 24 years; and willingness to participate in the study and complete inform consent procedures.

## **Sampling procedure and process**

For this study, both purposive and snowballing strategies were utilized to recruit six participants. The researchers already had premonitions that recruitment of the study participants would be a herculean task because they were not affiliated to any support body and also their secrecy that surrounds HIV and death. The General Hospital Wannune (GHW) is the only secondary health facility in the town; it is the only health facility that provides antiretroviral therapy (ART) for HIV infected patients and its social workers coordinate care for the children below the ages of 18 years that are orphaned to AIDS



and vulnerable to it. The researchers already obtained gatekeeper permission from the GHW management as part of the requirement for ethical clearance and this allowed the social workers to be contacted for the identification of potential participants. The researchers met the social workers and the purpose of the study was discussed with them, so that youths that meet the eligibility criteria can be identified and referred to the researchers. The two social workers that were given the task of first contact with participants identified three youths whose qualities (purposive sampling) permit answering of the research question (Cohen & Crabtree, 2006). In order to increase the depth of the findings, the purposively recruited participants were asked to refer people who they thought might meet the study inclusion (snowballing); additional three participants were recruited using this technique. For all the participants, this study was the first opportunity of talking about their experience after the loss of their parents to AIDS and they never thought anyone could be interested in their stories. It is important to note that none of the participants of this study has ever benefitted from any government support for AIDS orphans and they were not affiliated to any form of support source before and during the data collection.

### **Data Collection**

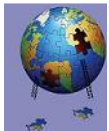
Understanding and getting close to the hardiness factors used by the study participants and not controlling was at the heart of the researchers. In-depth semi-structured interviews were conducted with individual participant because it provided a loose form of data gathering that enabled both the researcher and participants to diverge to pursue their narratives. The pre-determined questions does not prevent asking other questions that the researcher deemed necessary but using the same wording facilitated the generation of codes. The participants were interviewed twice, first interviews collected all necessary informations about how and what they were using as strategies to meet their needs and the second interviews was only to validate how their responses were reported and described by the researchers. The interviews were tape-recorded with the permission of the participants and were held in one of the discussion rooms of GHW library. It provided a comfortable, non-threatening and serene environment for the interviews. All participants validated the description of their responses.

### **Data analysis**

The method of phenomenological data analysis prescribed by Colaizzi (1978) was utilized to analyse the transcribed interviews. Colaizzi recommends reading and re-reading of the transcripts to acquire the feel of the needs of youth orphaned to AIDS and the hardiness factors they are deploying to meet these needs. The researchers comprehensively read the transcripts and got immersed in the way participants needs emanates, how they are making sense of their needs and how they are coping and meeting their needs. Significant statements pertaining to the phenomenon under study were then extracted and meanings were formulated. The meanings formulated were then categorized into cluster of themes that combined the commonalities in the participants' experiences. The themes were exhaustively described and it reflects the needs of youth orphans and the hardiness factors used in meeting these needs. The structure of the phenomenon which was exhaustively described by the researchers was validated by the participants' as the true reflection of their needs and what factors they were using to meet their identified needs.

### **Findings**

This section presents main themes that were related to the three themes of control, commitment and challenge that conceptualized hardiness. Aspects of the participants' coping strategies that suggests maladaptive coping were also highlighted to present areas where participants need hardiness education. The needs of the participants were also discussed.



## *Challenge*

The 'challenge' component of hardiness is a direct opposite of threat (Kobasa, 1979). Kobasa & Maddi (1984) defined challenge as openness to change and problem solving. For an individual strong in challenge; stresses are part of normal living and it is an opportunity to learn, develop and grow in wisdom (Maddi, 2006). In this study, parental AIDS illness started the cascade of events of how the participants were challenged by AIDS parental loss. As an illustration, one participant when asked how she experienced her parent's AIDS illness responded: "I experienced how a very active, vocal and chubby woman lost a lot of weight. I saw her strength vanish in front of me. She became someone that I had to feed; she lost her balance and was so dependent on me and my siblings for all activities" Another participant responded to the same question: "great responsibilities fell on me, especially when mother left us. I had to decide for father in some situations, looked over his business and fed him sometimes.....it was crazy"

The researchers questioned if the participants' experiences would be different if their parents died from another illness and majority said yes. Some of the participants responded by saying:

"I felt his prolonged duration of sickness prepared me for eventualities and made me learn some lessons independently. If it was to be a sudden death, let's say accident, it must have been somehow traumatic and my experience might be worse because I would not be prepared"

Another responded added: "if it was a sudden death, ahh! It will be different. You know if someone is sick, somehow you get a sudden acceptance that they might die every time you think about it. But if it was a sudden death, it will be shocking, traumatic and you won't be prepared"

The participants transformed from dependence to independence and some of them were happy they contributed to the wellbeing of their sick parent. As an illustration, one participant responded to how he experienced the event of his father's loss: "I finished preparing his meal and I was eager to make him judge if it was well cooked but I called him and he was not answering. I shook him, I saw no resistance". Additionally, some of the participants argued that being older during the time of parental death gave them the opportunity to appreciate what death meant and what to expect after the loss. A 24 year old participant when asked if her experience would have been different if she was younger at the time of her parent's death and she has this to say: "If I was younger, I would have been helpless because when he died I was able to work and assist the family but being younger meant that I won't only be helpless but powerless." Another 22 year old participant added that: "Yeah!!! Being older was advantageous because I was not in confusion over his death like my younger siblings who were confused".

The challenge of parental loss to AIDS started before the actual death of the participants' parents and this seems to have prepared them for what the future will hold. Most of the participants diversified and positioned themselves for the new responsibilities. Some of the strategies that participants used in meeting their new challenges were compromise, working extra hours, solidarity and continued belief that things will get better. Though the responsibilities of the participants increased significantly after the loss, the older age of the participants of this study meant that they have been active in the care of their sick parents and most of them expected the worse.

All the study participants have experienced life disruptions as a result of the AIDS parental illness and some of them were further challenged by family conflicts between parents, instability and multiple movements. One of the participants even expressed: "I did not experience what a family structure should be like....I sometimes ask myself, what am I going to do in my family if I have one, how am I



going to treat my husband? I wish I still had her around”. Significantly, a persistent source of challenge gleaned from participants narratives was concern and worry over the wellbeing of younger siblings. Most of the participants felt that their younger siblings have not come to terms with the death of their parents and most times they look up to them for this understanding of death. One of the participants also felt she has disappointed her dead mother and her siblings because after she decided to leave home for tertiary education, the younger brother joined a gang and was stabbed and the younger sister lost her moral dignity.

### **Control**

According to Kobasa & Maddi (1984), control is the direct opposite of powerlessness. Kobasa (1979) defined control component of hardiness as the extent to which the individual believe that they can influence the events of their life. In the description of their experiences in relation to AIDS parental loss, participants used phrases such as (your life suffers cracks which can't be fixed again in life; it's not nice it's you against the world and I just hate HIV, it crippled my life). Despite the devastating impact of AIDS on their lives, some of the participants engaged in activities that show that they are trying to exert influence on the activities going on in their lives. Most of the participants have been somewhat slowed down in their life achievements and meant that they have sacrificed significantly in order to cope with their new challenge. Great responsibilities fell on the participants after their loss and this was as a result of their older age and agency. In order to exert control on their situation, participants did not only look after themselves but they look after and cared for the surviving family members. When asked what has changed after the parental loss, participants responded saying: “I have to hustle for myself and my siblings. One of those choices I made was choosing to study Chemistry in tertiary, rather than Medicine because of the cost implications”. Furthermore, two female participants recounted how older men proposed marriage to them and advised them to quit school. One of them has this to say: “I refused the advances of men, I found a mentor who told me then that if I want to assist my life, I should forget about men, forget about having kids and get educated” Another participant described how he had to start farming and growing vegetables in their backyard because he wanted to be a good role model for his siblings and wanted to develop into someone that his late father would be proud of.

As part of the efforts to embrace options that will assist them in achieving better outcomes despite their financial, psychological and educational disadvantages; most of the participants re-took their previously failed Matric exams. A 19 year old participant who told the researchers his ambition to become a chartered accountant was asked how he intended to achieve his dreams considering his present challenges. The participant responded saying: “I will support myself with farming and I will also use my father's land as collateral to obtain loan to finance my education and that of my siblings”. The researchers even asked how the participants would advise other youths faced AIDS parental loss and some of them responded saying: “They should work hard and cooperate with one another in the family to enhance survival”. Another participant added: “I will advise those in the same situation like me to find something positive from the situation that will motivate. Giving up is not an option. They are not alone, this situation is not the worst, and there will always be a way”.

The above statements from the participants resonates their determination to engage in activities that suggests they are trying everything possible to take charge of their situation. Most of the participants also mentioned praying to God during difficult times and this suggests that spirituality is one of the means by which they draw energy for hope.





## ***Commitment***

The capacity to engage in activities such as work, family and interpersonal relationships is referred to as commitment (Harrison, Loisel, Duquette & Semenic (2002). Commitment gives individuals sense of purpose and serves as a repertoire from which resources can be drawn in the face of challenges. This subset of hardiness result into the development of social relationships and Kobasa (1979) comments that a strong sense of commitment to self is the most critically important component of hardiness. With the pervasive influence of stigma attached to HIV pandemic, it is not unusual to think that achieving and sustaining social connectedness might be a daunting task for AIDS orphaned youths. However, the participants of this study still managed to draw some support from external sources such as family, neighbours, church and friends. As an illustration, one participant discussed how she came to terms with the loss of her father

Before my father died, I used to think HIV is for certain people, I did not know that HIV is something that is very close to us. So it was the first time we saw someone with AIDS in our family. But my family is an open family that enables us to discuss everything and we don't have secret. That's the kind of family that I have and that is how I came to terms with reality and what to expect.

Another participant decided to take up a career in psychology so that she can understand the effects of HIV and AIDS on families and she intended to use those skills to be a counsellor with experience. The older age of the AIDS orphans in this study meant that most of them had younger siblings and all of them talked about the strength that lies in staying together as a group, watching after each other's back and the need to draw support from each other. A 22 year old participant highlighted the differences that existed in the way she and her siblings mourned the loss of their mother and how this facilitated better coping. The participant recounted that: "I woke up in the night always crying, my younger brother and sister were even the ones telling me to stop crying and I felt like I did not cope as they did. After several months and especially when we run to challenges, my siblings' cried and I had to stay strong and give them reasons why we couldn't break now. One of the participant also recounted how thieves broke into their house and how she informed her neighbours, who in turn informed the police. The participants of this study were sometimes assisted by family members, religious group, teachers at school and sometimes friends. Although outside support was not so pronounced in the lived experiences of the participants; most of them however realized the need for external supports for better coping. Participants listed special welfare, national mentor programmes, modelling programmes, educational and financial supports, and bereavement education for their confused younger siblings. However, only one participant talked about finding a role model and none of the participants sought professional care nor actively utilized social support.

## ***Maladaptive coping***

For all the participants interviewed in this study, this study was the first opportunity for them to discuss their parental loss to AIDS. Unsurprisingly, the participants expressed several emotions that have been repressed and all of them cried during the interview sessions. Most times the interviews had to be halted temporarily to enable the participants to cry and to all them to appraise their loss. Most of the participants discussed how their life was filled with anger that was either directed at self, family members or late parents: For instance, when a participant was asked if she could discuss any needs that arose in her life because of the loss of her father had this to say:



At the time of his death and even several months after, I just hated my dad, I was angry at him. I did not see so much on his part because of his way of life. He left the house to be with other woman and cared less for us and I got very angry with him.

Some of the participants' experience of persistent anger was borne out of the feeling that their sick parents were neglected by the extended family and they did not do enough to salvage the situation. One participant was still furious at an uncle and she explained:

I still get angry with my uncle when I remember how my mother died helplessly. All the other women in the neighbourhood and my uncle came around and they were giving her food and she was not swallowing. Up till now, I do not know why my uncle did not call an ambulance

Some of the participants also discussed the need for psychologist and professional counselling care but none of them has taken the effort to seek this kind of care. A participant when discussing the experience of her mother's loss commented that: "I had too much responsibility and sometimes I feel like I am going to break, I had no one to talk to and sometimes I feel like seeing a psychologist". Most of the participants are sometimes submerged in wishful things and hide their frustrations from siblings and other family members.

In order to cope with their new challenges which was dominated by increased responsibilities and the need to be independent, the older participants of this study all discussed about the issue of neglecting themselves in the process and were lamenting delay in their life achievements. One participant put it this way:

Somehow then I started thinking that life is not always about other people. I am here on earth on my own journey, I know taking care of my mother is something that I have to do but somehow I neglected myself. As I was striving to build a house for my mother, I neglected myself

While hardiness factors appeared in individual participant's transcripts, maladaptive and non-hardy coping also abounds. Most of this maladaptive coping are subtle and some of which can be described as a time bomb which can seriously compromise healthy social, physical, emotional and functional youth development. As earlier mentioned, the challenge of AIDS parental loss in the study participants started long before parental death and this meant that participants are constantly living in fear, uncertainty, anxiety and worry. Some of the participants expressed deep sadness over the pain of the past, the delay in social and academic achievements and the continuing emptiness as a result of the loss that cannot be replaced again.

## **Discussion**

In 2003, the United States Government announced the United States President's Emergency Plan for AIDS Relief (PEPFAR). At US\$ 15 billion, it was the largest single funding commitment for a disease in history (WHO, 2011). However, the changing world economic landscape meant that donor funding has also stagnated (UNAIDS, 2012). UNICEF (2009) comment that the needs of children and youths affected by AIDS continue to outstrip resources; the care, protection and support for AIDS orphans thus become difficult to maintain. There is no better time to empower AIDS orphans with practical coping skills. This study utilized a phenomenological approach because the examination of experiences provides a form of self-appraisal and provides skills and knowledge (Manser, 1984).

As Masten & Obradovic (2008) and Bentacourt & Khan (2008) explain, the wellbeing of young people affected by AIDS must be viewed as a dynamic process involving a number of ecological



levels (biological, family, community and culture) and these levels usually present their own unique risks, needs and strengths. This made UNICEF (2009) recognize that HIV-sensitive- rather than HIV-specific approaches are more appropriate in most HIV-impacted environments. While AIDS orphanhood might be an umbrella term that describes the phenomenon of parental loss to AIDS, it is important to acknowledge that age, living arrangement, community context, access to support and individual personality disposition can diversify the experience of AIDS orphanhood. Even among the six participants of this study, there were variations in the type of families they grew up.

The findings from this study confirmed many of the challenges and the coping needs of young people orphaned to AIDS around the world (Bentacourt, Meyers-Ohki, Charrow & Hansen, 2013; Cluver et al., 2012; Harms et al., 2010; Rooyen, Froot & Ricks, 2012; Doku, 2009; Cluver & Gardner, 2007). As earlier discussed, AIDS orphans above the age of 18 years are excluded from supports, aids and interventions according to international discourses; Nigeria Orphans and Vulnerable Children (OVC) policy also excludes this category of youths. While acknowledging that life is inherently stressful; parental loss in the absence of external support might not only mar their future but also impede the achievement of several Millennium Development Goals (MDGs) and also the halting of HIV and AIDS pandemic. The challenge facing health professionals particularly those working in the community health domains is how to improve their wellbeing and assist them to channel their youthful energies into productive and healthy outcomes. What the concept of hardiness contributes in this debate is assisting the AIDS orphaned youths to develop a set of attitudes (challenge, control and commitment) that provides the courage and motivation to do the hard, strategic work of turning stressful circumstances from potential disasters into growth opportunities (Maddi, 2006).

A longitudinal follow-up of AIDS-orphaned children with control groups of other orphans and non-orphans conducted in South Africa reveal that AIDS-orphanhood interacted with increased age to magnify the rise in levels of depression, anxiety and PTSD. This suggests that the older the AIDS orphans, the more they are vulnerable to the above mentioned mental problems. This might be connected to the parentified status that they assume during parental illness and after loss, as they not only worry about their own survival alone but also that of their siblings. Stein, Rotheram-Borus & Lester (2007) describe parentification as the early and pre-mature assumption of parental roles and adult responsibilities in children and adolescents before they are emotionally or developmentally prepared for such roles. In this study, most of the participants are taking significant part in the welfare of their family and the overwhelming responsibilities most times get them carried away in wishful thinking. In the USA, Orban, Stein, Koenig, Conner, Rexhouse, Lewis & LaGrange (2010) find that passive coping strategies such as wishful thinking was significantly associated with greater depression among their sample of HIV and AIDS affected youths.

In the present study, the impact of parental loss to AIDS tends to present at a later stage among the participants. The reason for this might be due to neglect of self and poor expression of emotions at the initial time of the loss. Most of the participants were either busy worrying about siblings' welfare, mother's health or some other aspects of care-giving that made them significantly ignore their own feelings of loss. Although Zhao et al., (2009) implicate stigma as interacting with AIDS parental loss in China to produce feelings of sadness, fear, anxiety, anger and loneliness among AIDS orphans; none of the participants of the present study reported any form of stigmatization. This might be because the whole community has been devastated by the AIDS epidemic and it is thus a community disease. It is important to acknowledge that the older age of the participant of this study afforded them the opportunity to have a better understanding of death; coming to terms with the reality and the consequences was quickly achieved by all of them. Contrastly, Thupayagale-Tshweneagae, Wright & Hoffman (2010) in South Africa and Woods, Chase & Aggleton (2006) in Zimbabwe report that not being told the truth about the nature of parental HIV illness and hiding the reality of death from AIDS



orphans significantly predicted distress among them This was not the case for the participant of the present study because they were older (above 17 years) at the time of parental loss whereas the participants in the other listed studies were younger (some as young as 7 years).

Salvatore Maddi, one of the founding researchers and authors of hardiness concept report that over 600 studies have been conducted on hardiness around the world as at the year 2006. Most of the studies on hardiness have concentrated on sports science such as recovery abilities of athletes after sports related injuries (Wadey, Evans, Hanton & Neil, 2012; Sindik & Adzija, 2013), military training and performance (Maddi, Matthews, Kelly, Villareal & White, 2012; Taylor & Pietrobon, 2011; Hystad, Eid, Laberg & Bartone, 2011; Orme & Kehoe, 2014); in acute and chronic healthcare settings (Akbarizadeh, Jahanpou & Hajivandi, 2013; Engel, Siewerdt, Jackson, Akobundu, Wail & Sahyoun, 2011; Hurst & Koplín-Baucum, 2005). Despite that the research on hardiness has been conducted across several disciplines and among several populations; the applicability of the concept among AIDS orphans have not been widely reported in the literature.

Several studies (Rich & Rich, 1987; Feinauer, Mitchell, Harper & Dane, 1996; Jackson, Firtko & Edenborough, 2007; Maddi, Kahn & Maddi, 1998; Maddi, 2004; Moazedian, Ahghar & Aref-Nazari, 2014) report that hardiness can be learned at any stage throughout the life course and recommend early hardiness education/training when the need is identified. The three attitudes of hardiness are a cognitive/emotional amalgam constituting a learned, growth-oriented, personality buffer (Seligman & Csikszentmihalyi, 2000). Conceptually it is therefore insufficient to have only one, or even two of the hardy attitudes. All three are needed in order to be courageous and turn negative life circumstances into one's advantage (Maddi, 2006; Kobasa & Maddi, 1984).

Even though the participants of these studies are high on the challenge and control component of hardiness; their help seeking behaviour (commitment) is defective. Most of the participants of these studies are only reliant on the solidarity between themselves, siblings and surviving parents. The use of external source of support such as counselling services, psychotherapy, extended family and community services were lowly utilized. In a sample of four hundred twenty five AIDS orphans children in South Africa; Cluver, Fincham & Seedat (2009) find that orphans with high perceived social support demonstrated significant lower levels of Posttraumatic Stress Disease (PTSD) symptoms after both low and high levels of trauma exposure. The construct of hardiness is appealing because it continues to be easier to focus on individual problems and solutions rather than look for and try to change the social factors that affect health status and wellbeing (Low, 1999).

From the conceptualization of hardiness construct, one can argue that this category of AIDS orphans is not hardy and this can lead to various deleterious outcomes that can compromise their wellbeing and health in the long run. Some of the participants of the current study are even showing signs of psychological distress that can significantly affect their healthy youth development and even their adulthood. The participant of this study already possess the challenge and the control component of hardiness and their wellbeing can be further improved if they can be trained on utilizing the commitment component of hardiness. Since hardiness can be learned and has been demonstrated that mastering of hardiness personality can be achieved within six to 18 months of training (Judkins, Reid & Furlow, 2005; Judkins & Ingram, 2002; Maddi, 1987; Rowe, 1999, Maddi et al., 2012; Moazedian, Ahghar & Aref-Nazari, 2014) this paper argues that the prospect of hardiness education should be explored in this cohort of AIDS orphans.

While qualitative approach used in this current study affords the researchers to get close to the lived experience of the participants; the small sample size in this study mean that caution should be exercised when interpreting findings. Although the participants have diverse experience of AIDS



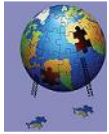
orphanhood which increased the depth of the study and opened the researchers to new ways of knowing; the generalizability of this study is not guaranteed. The small sample size in this study is partly due to inadequate healthcare record keeping, high mobility of AIDS orphans, sacredness of death and culture of silence that might be in the study area. This study extended the theory of hardiness and provides a conceptual lens that health professionals can utilize to assist AIDS affected youths. Health professionals need to individualize the care of AIDS orphans and examine what hardiness education is needed among their clients. Health educators need to be aware that AIDS affects youths in different ways, some of the AIDS orphans might be high in control and challenge but low in commitment as the case of this study while some might need education in how to take control of their situation.

### **Conclusion and recommendations**

Parental loss to AIDS is a major disruptive life event that can truncate healthy youth development if appropriate strategies are not instituted to cater for survivors wellbeing. This study elicited the role that the older age of the participants and the experience of parental AIDS sickness played in their preparation for parental loss and uncertainties (challenge). The experience of parental loss at an older age provided opportunities for the study participants to search for purpose in life (control) despite their chronic stressors that were attributed to economic, social, and parental loss. However, majority of the participants cannot be regarded as coping in a hardy way because the analysis revealed themes of maladaptive coping that is likely to jeopardize their wellbeing in the long run. The hardy attributes lacking in the participants of this study are in the area of commitment and this meant low utilization of external support and internalizing of challenges. The participants need to combine the three attributes of hardiness (control, challenge and commitment) in other for their wellbeing to be improved. The findings of this study thus provide important information that healthcare professionals and health educators can utilize to assist this vulnerable population. Healthcare workers need to individualize the care of youths who are experiencing parental loss to AIDS; so that the hardiness traits that they possess can be identified and to determine what hardiness education is needed for them to cope more effectively. The study recommends that curriculum planners in Nigeria accommodates the introduction of hardiness concept in the training syllabus of health professionals training and education.

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