

# “I’m Not Going to Die from the AIDS”: Resilience in Aging with HIV Disease

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**Purpose:** Adults aging with HIV/AIDS can experience resilience in spite of the deleterious affects of the disease. This study seeks to examine the lived experiences of older adults with HIV/AIDS as it relates to strengths and resilience in dealing with this devastating disease. **Design and methods:** Semistructured in-depth interviews were conducted with 25 adults, 50 years and older, living with HIV/AIDS. The interview transcripts were analyzed using constant comparative methodology following the tenets of adaptive theory. **Results:** The majority of informants expressed experiences of resilience and strengths as related to living with HIV/AIDS. Seven major themes emerged from the analysis including self-acceptance, optimism, will to live, generativity, self-management, relational living, and independence. **Implications:** The research identified the importance of strengths and resilience among older adults living with HIV/AIDS. Further research is needed to explore these phenomena with larger samples. Practitioners should identify and implement methods for assessing resilience among older HIV-infected adults.

*Key Words:* HIV/AIDS, Older Adults, Strengths Perspective, Resilience

older adults living with chronic diseases, such as HIV/AIDS. The purpose of this article is to report on how resilience manifests in the lives of adults aging with HIV/AIDS. Advances in treatment and medical management of HIV disease are enabling individuals diagnosed with HIV/AIDS to survive for many years with what has become, for many in the United States, a chronic illness. A recent study to determine the lifetime costs of HIV care estimated the life expectancy of someone entering HIV care in 2006 to be in excess of 24 years (Schackman et al., 2006). The use of highly active antiretroviral therapy has made it possible for individuals infected earlier in life to live into late adulthood.

Centers for Disease Control and Prevention (CDC, 2009) surveillance data estimated that by the end of 2007, 156,511 individuals aged 50 and older were living with HIV/AIDS in the United States, up from 105,855 only 3 years previously. In addition to the aging of long-term survivors, older adults have continually represented a substantial proportion of new HIV/AIDS cases. According to CDC (2008) data, 15% of all new HIV/AIDS cases in the United States (based on data from 33 states with long-term, confidential name-based HIV reporting) occurred in persons aged 50 and older. Older adults represent a growing number of individuals living with HIV/AIDS, both in terms of new infections and a growing prevalence of long-term survivors.

Few studies have examined resilient characteristics across the life span and even fewer have highlighted manifestations of resilience among

Although age 50 is not a typical definition of an older person, particularly in the gerontological literature, there is a historical precedent for this age distinction. At the onset of their surveillance reporting, the CDC stratified all individuals with AIDS more than 49 years of age into one age category. The scientific literature has also adhered to this classification, routinely referring to individuals 50 years and older, who are infected with HIV, as “older adults” (CDC, 1998; Kirk & Goetz, 2009).

Research on HIV infection among older adults has unearthed a multitude of deleterious effects on this population. Physical issues include comorbidity and faster disease progression (Kirk & Goetz, 2009). For example, CDC (2009) data indicate that although approximately 36% of persons aged 30–34 years receive a late diagnosis (defined as being diagnosed with AIDS within 6 months of an HIV diagnosis), the rate rises to nearly 50% for individuals aged 50–54 years and 56% for those 65 and older. Additionally, individuals in the oldest age groups have a shortened period of survival following an AIDS diagnosis. Although HIV-infected older adults have a virological response to treatment that is superior to younger adults, they are more susceptible to adverse effects; have lower rates of immune reconstitution; and a greater number of comorbid conditions, including renal, cardiac, and liver disease (Kirk & Goetz).

The literature also documents various social problems for older HIV-positive adults. The *Research on Older Adults with HIV* study (Karpiak, Shippy, & Cantor, 2006) reported that more than 40% of respondents identified their support network as inadequate. Additionally, Emler (2006a) found adults aged 50 and older living with HIV/AIDS to be significantly more isolated than their younger HIV-positive counterparts. Loneliness was also shown to be significantly associated with depression in older HIV-infected adults (Brennan & Karpiak, 2010). Other psychosocial issues that have been identified with this population include stigma and discrimination (Brennan & Karpiak; Emler, 2006b), concerns for disclosure (Emler, 2008), and psychological concerns, including depression and suicidal ideation (Heckman, Kochman, & Sikkema, 2002; Kalichman, Heckman, Kochman, Sikkema, & Bergholte, 2000).

Less research attention has been focused on the strengths and benefits of life experiences that older adults living with HIV bring to bear upon their

situation. Siegel, Raveis, and Karus (1998) were some of the first researchers to document the advantages age brought to living with HIV/AIDS. Their respondents noted the presence of wisdom, increased respect for health and life, and a decreased fear of disability as advantages of aging with HIV/AIDS. More recently, Vance and Woodley's (2005) pilot investigation of 12 older men and women with HIV disease revealed several sources of strengths. These individuals reported that social support was their most central source of strength, with acceptance of the aging process, spirituality, community involvement, and self-awareness identified as additional sources.

There is some evidence that older adults living with HIV disease also exhibit resilience in their ability to adapt to their condition over time, enhancing their quality of life and achieving a level of successful aging. Raveis, Selwyn, and Frederickson (2008) studied resilience among older minority adults with advanced HIV disease. They found that the majority of older adults felt good about themselves, emphasized the importance of being at peace with themselves, found meaning in their life, and shared their feelings with family.

## Conceptual Frameworks

This study was informed by two conceptual frameworks that have been applied to gerontological research and practice—resilience theory and the strengths perspective. Both frameworks were developed for application with other populations and have been extended to work with older adults.

Although there is no universally accepted single definition of resilience, it is seen as successful adaptation to negative life events, trauma, stress, and other forms of risk and as having the capacity to cope with significant change (Green & Conrad, 2002). Protective factors, such as family and community supports, act as buffers against negative outcomes and help promote adaptation (Wagnild, 2003). Rutter (1987) suggests that protective factors can also be a personal trait or quality unique to an individual. Much of what we know about resilience derives from seminal studies in the child development field as researchers investigated the risk and protective factors observed among “at-risk” children (e.g., Garmezy, 1993; Hawkins, Catalano, & Miller, 1992; Werner, 1984). These studies have provided support for in-depth investigations into factors that promote resilience in other age groups, including older adults.

In recent years, an approach known as the strengths perspective has emerged in the practice literature. Initially developed for use with adults experiencing severe and persistent mental illness (Rapp, 1998), the approach has been extended to older populations (Chapin, 1995; Chapin, Nelson-Becker, & MacMillion, 2006). The strengths perspective recognizes that there is reciprocity between the older person and their social environment even in the most difficult circumstances. The underpinnings of this perspective come from social constructionist theory, which posits that our interpretation of human interactions, even serious social problems, are based on social and personal constructed views of reality (Chapin; Chapin et al.).

The strengths perspective represents a shift in traditional service provision, particularly related to efforts to promote successful aging. Practitioners identify and embellish clients' strengths and resources to promote the actualization and achievement of clients' goals and plans for success (Saleeby, 1997). Fast and Chapin (1997) suggests that this places self-determination of older adults as a central value, magnifying the worth, dignity, and uniqueness of older adults, in contrast to the medicalization of aging, which highlights disabilities and seeks to protect them from injury and debilitation. Such perspectives are very relevant to older people living with HIV/AIDS.

## Design and Methods

Qualitative research allows for serendipitous discovery. Kaufman (2002) suggests that serendipity shapes the fieldwork experience that "one cannot know ahead of time which cultural logics or formulations will emerge as interesting or which associations and connections should be pursued until one immerses oneself in the particular cultural milieu" (p. 69). This is the case with the findings presented in this study. The original research (Emlet, 2006b) focused on questions of how HIV stigma and ageism are experienced among older adults.

### Data Collection

Twenty-five men and women, aged 50 and older, living with HIV/AIDS in the Pacific Northwest, were part of the research study "HIV Stigma in a population of adults age 50 and over." During in-depth semistructured interviews with these individuals concerning their experiences of stigma and

ageism, the topic of strengths and resilience emerged naturally and spontaneously.

### Procedures

Study procedures were approved by the University of Washington Institutional Review Board. Participants were recruited for the original study from local AIDS service organizations, county public health, infectious disease clinics, and medical centers throughout one county in western Washington. The county is ranked second in cumulative number of HIV/AIDS cases for the state (Washington State Department of Health, 2010). Purposive sampling techniques were used due to the relatively small number of available informants. Inclusion criteria consisted of age (50+) and positive HIV status. At the initial connection, the study was described and contact information provided for the principal investigator (PI). Informed consent was signed at the initial appointment with the PI. Participants were asked to grant permission for audiotaping their research interview; no participants refused.

Interviews were conducted at local AIDS service organizations, the PI's office, or participants' homes. Participants supplied a pseudonym (used throughout this document) for the remainder of the interview, insuring confidentiality while personalizing conversations and data reporting. Semistructured in-depth interviews, averaging 2 hr in length, were conducted. Participants were compensated with a payment of \$25. All interviews occurred between November 2003 and December 2004.

During the interview, participants were asked to respond to two open-ended questions: "Tell me about a time that you felt discriminated against or mistreated because of being older and having HIV disease" and "What do you think society should know about being older and having HIV disease?" All the information that emerged related to the participants' strengths and resilience was derived from their answers to these initial questions and subsequent follow-up questions.

### Data Analysis Strategies

The audiotapes of these interviews were transcribed. The written transcripts were then reviewed by the PI and a research assistant for accuracy, by replaying each interview tape while reading the transcript to correct for inaccuracies and inconsistencies. Initial coding occurred after the review of each transcript. The process utilized by the researchers

follows the tenets of adaptive theory (Layder, 1998), which acknowledges that theory generation can be enhanced if the research begins with some prior theoretical ideas that will “help to both organize the data and stimulate the process of theoretical thinking” (p. 54). Each transcript was initially coded by two researchers working separately to identify the thoughts and ideas disclosed by the participants that communicated concepts of strengths and/or resilience. The constant comparative method was used to identify variations within concepts and broader categories of phenomena. However, as consistent with adaptive theory, we acknowledge the potential influence of the conceptual frameworks of resilience and strengths in the coding.

The researchers met approximately once weekly to discuss codes and reach consensus on higher order concepts, ensuring that coding saturation was achieved and high intercoder reliability was maintained. Two members of the research team independently read and analyzed all the transcripts; they identified the various themes and assigned them specific codes. Interrater agreement of the codes assigned was assessed and was found to be excellent (i.e., exceeding 90% agreement). Isolated coding discrepancies were resolved through joint discussion and verification of the text with other interviews having the same code. This process yielded approximately 32 codes, ultimately distilled down to seven major themes. All 32 codes emerged from the original double-coded data analysis of the transcripts from the 25 informants. By comparing and unifying emerging themes, constructing typologies and classification schemes, the researchers jointly consulted over newer and broader concepts identified in the data and reached a shared consensus on nine major themes: self-acceptance, optimism, will to live, generativity, self-care, self-acceptance, self-control, social support, and independence. After further review of the double-coded material, the researchers agreed that the broader theme of self-management encompassed the concepts of self-care and self-control. Thus, self-management became a higher order category. Additionally, social support as an original theme was replaced with relational living to better exemplify the fact that the majority of informants cited having personal relationships with others (either formal or informal supports) as significant to their living with HIV/AIDS. Condensing these themes resulted in the seven themes reported here.

Table 1. Sample Characteristics

Variable	N (% or <i>M/SD</i> )
Age	50–72 ( <i>M</i> 56.1 ± 5.75)
Gender	
Male	17 (68)
Female	8 (32)
Race/Ethnicity	
White	15 (60)
African American	9 (36)
Non-White Hispanic	1 (4)
Living Arrangements	
Alone	13 (56)
With family of origin	4 (16)
With partner/spouse	7 (28)
Education (in years)	7–17 ( <i>M</i> 12.9 ± 2.6)
HIV Exposure	
Men having sex with men	9 (36)
Heterosexual intercourse	9 (36)
Injection drug use	4 (16)
Other	3 (12)
AIDS	19 (76)
HIV	6 (24)

### Participants

The characteristics of the sample are shown in Table 1. Participants ranged in age from 50 to 72 years, the majority, 76%, were between 50 and 60 years of age (*M* = 56.1, *SD* = 5.75). Sixty-eight percent were male and 40% were people of color. All but one of the non-White participants was African American. The average education level was 13 years (*M* = 12.9, *SD* = 2.62). The majority, 72%, were retired, and 52% lived alone. Thirty-six percent reported having been exposed to HIV through heterosexual contact, 36% through men having sex with men, 16% through injection drug use, and 12% were exposed through contaminated blood or had an unknown risk factor. Although the length of time since first diagnosis was not captured in the interviews, the majority, 76%, had been infected for some time, having met the CDC criteria for an AIDS diagnosis. Sixty percent had been on Medicaid in the past year.

### Results

Strengths and resilience were identified in the majority of interviews through the informants' direct description of beliefs, actions, and behaviors. An exploratory model of resilience and strengths, informed by Saleebey's (1997) principles of the strengths perspective and the application of resilience (Wagnild, 2003), form the major themes that emerged from the data.



## Themes

Analysis of the participants' narrative accounts related to aging with HIV disease revealed seven major themes: self-acceptance, optimism, the will to live, generativity, self-management, relational living, and independence.

*Self-Acceptance.*—Eight participants (36%) expressed feeling comfortable with themselves and who they are at this stage of their life. They acknowledged that self-acceptance was central to overcoming the negative effects of HIV/AIDS and the complexities of aging with such a stigmatizing disease. This is illustrated by a comment from Taleef (age 56): “You got to love yourself, you got to want to do what you need to do for yourself.” Similarly, Louis (age 64) showed self-acceptance in stating: “I just try to like myself. I'm ok with being me.” Bob (age 52) emphasized the utility of acceptance when confronting aging: “It's been fine for me because I just accept growing older. I don't wanna act like or think that I'm still 25 or something.” Paul (age 53) compared being older to a bottle of wine: “The older you get, the better, the more refined it is. It's a lot of positiveness about it.” Ohms (age 56), explained simply: “Be who you are, and be glad you're still here.” His comments highlight the life-affirming value of prolonged survival with HIV disease.

*Optimism.*—The theme of optimism encompassed having a positive outlook on aging with HIV, maintaining future mindedness, feeling upbeat about life, and remaining hopeful about one's continued well-being. Sixty-eight percent of the participants reported having a positive outlook on aging with HIV disease. They remained open about their potential to accomplish their future goals, maintain good health, and continue to positively cope with the disease and the effects of aging. This feeling of optimism about the future is conveyed simply in Taison's (age 57) comments: “I see a lot of years ahead.”

Their narratives revealed it took a conscious effort to not have living with HIV/AIDS substantively impact future plans and feelings of well-being. Taleef (age 56) expressed how he maintains a positive outlook and attempts to put his situation into perspective:

In one way, it got my spirits down, but then I was always the type of man that tried to turn a bad

situation into something bright and good . . . basically for myself because I look at it [as] I may have a problem [but] there's people out there with worse problems than me.

Pete's (age 51) statement illustrates how applying a life-course perspective to living with HIV enabled him to regard the disease as a barrier that can be overcome, just like any other barrier an individual might face in a lifetime: “You know, there's gonna be hurdles in anybody's life. You know, you have to learn to get over the hurdle . . . . If everybody let every hurdle bring them down, we wouldn't have half the people here that we have now.” Similarly, Christa (age 51) explained that she viewed HIV as a small manageable aspect of her life: “Here I am. I love life. I'm having a great time you know, its [HIV] one of those things on the side of my life that I cope with. Other than that, life is lovely and I wouldn't trade it for anything.” Carol (age 52) also shared her proactive approach to growing older with HIV: “It's not really a big thing to me. I mean, I take my medicine, I go on with my life. I don't think about the AIDS anymore.”

*Will to Live.*—Multiple participants (36%) expressed a strong belief that living well with HIV/AIDS and surviving the debilitating course of the disease was possible given advances in HIV/AIDS treatment, research, and a growing knowledge and understanding of HIV/AIDS. Consistent descriptions of survival, longevity, purposeful living, and fighting the disease emerged from their testimonies. These accounts were thematically labeled as will to live.

Ohms (age 56) expressed a strong desire to survive and live life for as long as possible. “The world's going to keep turning whether I'm here or not here. So, I want to be a part of it as long as I can . . . . Life is still worth living.” Carol (age 52) simply shared: “I'm not going to die with the AIDS; I'm going to live with it.” Barb (age 57) stated: “I just want to live until I can't.” Although she expressed feeling grateful for having lived her life, she voiced her intent to continue living life to the fullest explaining: “At 57 years old, I've had a good life, and I'm already looking at the second half of life. So, it does sadden me, but you know, no one leaves the planet without dying.”

Steve (age 51) attributed his positive outlook about surviving HIV disease to the medical advances and treatment improvements that have

been made: "I've noticed that the medications have improved so much that I'm not so stressful as far as being ill or dying from it as I used to be." Similarly, the treatment advances that have led to increased longevity with HIV disease have enabled Paul (age 53) to confidently assert that he is not dying but living with HIV disease: "Being HIV positive is not a death sentence. . . . I'm living with AIDS, I'm living with HIV, I'm not dying with it."

*Generativity.*—Ten (40%) respondents expressed aspirations to give back to their community and society as a whole through advocacy, selfless acts of service, and education of younger generations. Christa (age 51) shared her belief that older HIV-infected individuals, given their age and lived experience, have an educational mandate: "I just think that people living with HIV over 50 . . . have a huge responsibility to be educators. I guess my position has always been that I'm more concerned for the next generation than for myself." Similarly, Taleef (age 56) also proposed a societal imperative of performing an educational service: "You have to give something back; older people especially. What we learned, we can't take it with us to the grave. Don't be that selfish." Wayne (age 59) believes older individuals are in a unique position to intervene and prevent the spread of HIV by informing and teaching others about their experience. He spoke about educating students in classes about HIV/AIDS: "First off, I'm going to tell them about everything I know about AIDS and HIV. Then I tell them my story, how I became involved with AIDS and HIV. Then I talk about prevention and how dangerous it is and what it does to a person."

The participants' comments also reflected their belief that, as an older person, their life-course experiences provided them with wisdom and insights about life that would benefit younger generations. As Ohms (age 56) explained: "We're walking history, walking history means that we've been here a long time . . . . There are those who are coming behind us [who] can learn a lot from us. They can benefit." When asked what are some things he believes the younger generation should understand, Terry (age 51) responded: "Everybody tries to get along in this world young or old. Of course, they probably have a different viewpoint than we do, but we can learn from each other. And that might help us grow. We can give them advice [because] we've been through what they're going through now."

*Self-Management.*—A major theme to emerge in 68% of the interviews was the concept of self-management. This theme included concepts of self-care (i.e., taking medications as prescribed, making regular doctor visits, maintaining a healthy balance of diet and exercise), personal responsibility (i.e., refraining from drugs and risky sex), and practicing self-control. Juanita (age 51) noted the importance of taking control over one's actions and behavior in order to manage the disease: "I found out from livin', in order to live longer with HIV, you need your proper rest. You can't keep doin' things that you were doing. You got to accept it. You can't be partying all night long." Similarly, Cricket (age 51), who volunteers speaking to junior high school children about HIV, recounted: "When I go to talk at schools to kids, I'd even ask them at first, I'd go: 'Do I look like a person walkin' around with AIDS?' An[d] they all say: 'No'. So, it's because I look healthy; I keep myself healthy, I try to." Alex (age 51) focused on personal responsibility: "It's up to the individual to be proactive about their disease."

Another aspect of self-management related to the efforts informants took to exert control over their disease condition. Kenny (age 60) recounted: "As far as the old fashioned way of dealing with people, street people, it's not the answer. The basic thing is working, to read more, to handle yourself in a better fashion and to learn more about HIV." Eric (age 72) listed a range of health promotion activities he adheres to in managing his HIV disease:

"I maintain a very healthy lifestyle, [I] diet, exercise, the whole thing and doing well is what counts. So, I'm in pretty good shape for being this far along with the diagnosis. What are you doing as an individual to cope with the condition? I think it's how a person handles it himself. You could either give in to it or you can fight it."

His comments also illustrate the heightened sense of personal control and mastery he derived from these efforts.

*Relational Living.*—The participants' accounts established that various types of formal and informal support systems, including close personal relationships, memberships in recreational activities, and/or HIV/AIDS-related support groups/organizations, also contribute to their efforts to live with HIV.

Family was a major source of comfort and support in managing the challenges of HIV/AIDS.

Louis (age 64) described the steadfast family support he receives: "My two sons and my brother, nothing has changed [since learning his HIV status]. They're with me, they ask me how the medicines are doing." Todd (age 63) revealed a similar relationship with his brother: "I call him a couple times a month and talk a couple hours at a time." Multigenerational relationships are particularly meaningful. Taleef (age 56) related his grandchildren's unconditional acceptance of his situation: "My grandkids know. I've set them down and I've told them about Grandpa. They don't care." These comments highlight the strength participants obtained from their family's unwavering allegiance to them and their unqualified acceptance. George (age 52) shared how being in a long-term relationship buffered the negative societal reactions to his situation: "I've been in a relationship for 21 years and because of that have not had to deal with a lot of the loneliness, the stigma of loneliness that is a very large part of being gay and older."

Some individuals noted that their HIV status provided the catalyst to reshape problematic relationships. Mary (age 55), who has moved in with her elderly parents (both in their 80s) since her diagnosis, had not yet disclosed her HIV status to them. However, by living with her parents, her relationship with them has improved to such a degree that she now feels she can tell them: "Now that I'm living in their house and our relationship has really improved, I've been enjoying staying with them [and] getting to know them better, that now might be a good time to talk with them about it [diagnosis]."

Although relationships with family and partners were a profound source of support, the informants' remarks revealed that relational living extended beyond individuals with close emotional ties. Eric (age 72) disclosed how the support networks available to him through his church and theater group activities were helpful: "It's sure good to have somebody. It would be very difficult for me to think that I didn't have anybody—it's such a desperate thing. If you have no support system of any kind, that's sad." Similarly, Jim (age 64) explained how his involvement in a recreational group with age peers is a source of social support as he ages with HIV disease: "Most of my dealings are with senior citizen at bowling alleys, I do a lot of bowling with the seniors and stay pretty much in the senior's league." Since these interviews were conducted, the man known as Jim has died. The first author (C. A. E.) attended his memorial service and the importance of his relationships

with his bowling community was evident by the large numbers of bowlers present who shared their testimony to him as a person.

Persons aging with HIV also benefited from social relationships with other similar individuals. Wayne (age 59) explained the value of belonging to a support group for persons with HIV:

We have this support group, if I didn't have that support group, I wouldn't know anybody. But we have this support group for heterosexuals with AIDS through the foundation . . . it's where you can talk about things that pertain to your situation and you meet people like yourself.

Relational living suggests that social connectedness whether family of origin, sexual partners, friends, or groups, gives meaning to their lives, makes them feel valued as a person, and enables them to engage in reciprocal relationships, thus giving them a sense of contributing and feelings of self-worth while knowing that they are not facing this situation alone.

*Independence.*—More than half of the participants were living independently (52%). The concepts of being self-supporting, self-reliant, looking to oneself as a resource, and managing one's own care encompassed behaviors and self-perceptions of mastery and control in aging with HIV disease. These concepts relate to the theme of independence. This sense of confidence in one's personal ability to manage their illness is reflected in Barb's (age 57) statement: "I'm feeling that there's nothing that anyone outside of myself can do to help me." Pete's (age 67) comments place the capacity to be self-reliant into the context of being an older person: "They [older people] handle things by themselves easier, they're not as dependent on other people." Pete's narratives revealed further that his position of fierce independence and adaptability stemmed from his life experiences. As he shared: "If you don't like me, get the hell out of my way. I mean if my roommate was to throw me out tomorrow fine. I'm not as scared. I've started over before and I'll do it again if I have to."

Others echoed this viewpoint, their discourse explicating that self-reliance and independence were internal, gained over the life-course. For some, this realization of acquired strengths precipitated a dramatic shift in self-perceptions. Taisong (age 57) offered:

I've changed over the years. It's like, I don't care who knows, everybody can know.

I started to realize it is such a waste of time to worry about what anyone else thinks in respect to how they think about me, because then I'm not being, as Shakespeare says:  
"To thine own self be true."

## Discussion

In-depth, semistructured interviews, focusing primarily on experiences of stigma and ageism, enabled 25 HIV/AIDS-infected adults aged 50 and older to articulate their reactions to aging with HIV disease. The important presence of resilience and personal strengths in these individuals' lives emerged as a serendipitous finding. Their experiences are consistent with findings from the limited research that has been conducted on the positive elements older adults bring to living with HIV/AIDS.

Self-acceptance emerged as an important theme in the lives of these older adults. This concept appears consistent with what [Wagnild \(2009\)](#) has labeled equanimity and describes as "sitting loose and taking what comes, thus moderating the extreme responses to adversity" (p. 106). It also reinforces the findings of [Raveis and colleagues \(2008\)](#), who noted, in their study of 109 individuals facing the end of life, the importance of coming to terms with their situation. The concept of accepting aging and advancing HIV, in addition to enveloping past life experiences, can be characterized as what [Siegel et al. \(1998\)](#) labeled wisdom or the ability to recognize and utilize one's own strengths and limitations. This aspect of self-acceptance allowed individuals to move forward with their lives rather than remaining stuck and mired in regrets from prior actions and behaviors.

Optimism was an important theme reflecting a positive outlook and future mindedness. Manifested as the ability to look forward and set goals, it fostered efforts to maintain good health. [Raveis and colleagues \(2008\)](#) noted as well the importance of positive attitude in their study, whereas [Wagnild \(2009\)](#) observed that perseverance can be regarded as the willingness to continue the struggle to reconstruct one's life and remain involved in the midst of adversity. Such a reconstruction requires one to look forward with some element of optimism. It became clear that many of the informants in this study achieved that perspective.

Closely connected with optimism is the will to live. The importance of survival and doing battle

with the disease emerged as testimony to the tenacity of these individuals. Their will to live and their underlying purpose in doing so are consistent with the element of meaningfulness as derived from the resilience literature. In this context, meaningfulness represents the realization that one's life has a purpose and there is something for which to live.

[Lewis and Harrell \(2002\)](#) identified altruism as a manifestation of resilience. For a number of the individuals in this study, their purpose for living was associated with generativity—a sense of concern for the well-being of future generations ([Hooyman & Kiyak, 2008](#)). Providing education and advocacy were identified as an important element in their lives. Although none of the participants framed it in this way, [Raveis and colleagues \(2008\)](#) uncovered the importance of being a role model for others in their research. It appears that many of the individuals in this study served that function in broader society relative to HIV disease. Although generativity is typically external (giving back), several individuals noted an internal element. They saw themselves as a part of history, something larger than themselves. By sharing that history, their legacy was passed on through education. The prejudice, stigma, and discrimination endured by many of these informants, due to their HIV disease and sexual orientation, were part of their lived experiences and constitute the legacy they were motivated to share.

Continued optimism and the desire to assist others were inextricably tied to self-management. Individuals relied upon their internal strengths for continued adherence to HIV medication regimes and avoidance of previously detrimental lifestyle elements, such as drug use and unsafe sex. Self-management is consistent with what [Raveis and colleagues \(2008\)](#) categorized as transformed lifestyle. It also echoes [Siegel et al. \(1998\)](#), who noted that with age comes increased respect for health and life. In addition, it is congruent with [Wagnild's \(2009\)](#) concept of being self-reliant, continually drawing upon one's strengths and capabilities to guide one's actions. Although the men and women in this study acknowledged the importance of others, many observed that they were responsible for their own self-preservation.

The theme of relational living attests to the fact that these individuals are aware of the significance of others in their lives. Family, sexual partners, friends, and social groups were all regarded as sources of strength. Their optimism for the future



and the sense of responsibility these individuals expressed helped them forge new relationships and reestablish others previously strained due to prior behavior. Raveis and colleagues (2008) attest to the importance of family for positive adaptation to advanced HIV disease. Vance, Struzick, and Masten (2008) point out the association of social competence and hardiness in HIV-infected older adults. The present analysis revealed that meaningful relationships go beyond family and sexual partners and include the support received from support groups and other social ties.

Finally, seemingly juxtaposed to the value of relational living is the theme of independence. Although having others to rely on for help and guidance is important, self-reliance emerged as of consequence in these individuals' lives. This theme appears to represent what Wagnild (2009) refers to as existential aloneness. She suggests this trait of resilience "is the realization that each person is unique and that while some experiences can be shared, others must be faced alone" (p. 106). Wagnild (2009) proposes that aloneness provides a sense of uniqueness. Perhaps it is this sense of uniqueness that helps manifest the other aspects of worldview (i.e., self-acceptance and will to live) evident in the present analysis.

The qualitative themes emerging from the lived experiences of these individuals substantiate the conceptualization that guided this examination. The seven themes emerging from these narratives uphold the resilience characteristics Wagnild (2009) posits. The themes align well with Green and Conrad's (2002) second generation of resilience research, which emphasizes coping and the ability to overcome adversity.

Several principles of the strengths perspective (Saleebey, 1997) were also apparent in these interviews. The conceptual principle that all individuals have strengths was evident in their discourse. Although these men and women were from multiple stigmatized groups living with HIV/AIDS, often having other chronic illnesses as well, their accounts revealed strengths. They used their experiences, many negative, as growth opportunities, supporting the underpinnings of the strengths perspective.

Overall, the individuals in this study demonstrated an ability to be resilient as they are aging while burdened with the effects of living with a chronic life-threatening disease. Given the increasing prevalence of chronic conditions across the life span, there is a need to expand the concept of successful aging to incorporate attention to the behav-

iors and characteristics that enable older adults to optimize quality of life even when faced with disease and disability. The findings from this analysis provide empirical support for a model of successful aging developed by Kahana and Kahana (2001) that applied to adults aging with chronic, disabling, and life-threatening conditions, specifically HIV/AIDS. Their Preventive-Corrective Proactivity (PCP) Model of Successful Aging proposes various psychological and social outcomes as indicative of high quality of life. Indeed, the men and women in the present analysis displayed in their conversations the dispositions of successful aging (e.g., feelings of hopefulness, sense of life satisfaction, expression of altruism, positive self-esteem) posited in the PCP model. Furthermore, their narrative accounts illustrated that although they are aging with HIV disease, it was possible to retain meaning in life, psychological well-being, and maintenance of valued activities and relationships. These findings support the utility of applying Kahana and Kahana's PCP model to further understand the mechanisms that promote successful aging and a high quality of life in situations of illness and disability.

### *Limitations*

A number of study limitations need to be acknowledged. First, participants were recruited from a limited geographic area (one county), using purposive sampling techniques. Second, although all participants who were successfully contacted agreed to be interviewed, the potential exists that recruitment efforts did not reach those older adults with HIV/AIDS who might be less resilient and have experienced a different potentially more negative affect related to HIV disease. Third, the data for this analysis emanated from a study focusing on stigma and discrimination. The opportunity for further follow-up with informants concerning the present themes identified was not feasible. Finally, the study did not capture information on time since diagnosis. Although their narratives accounts indicated that none of the participants were newly infected, the duration of survival following an HIV/AIDS diagnosis may affect one's views on growing older, disclosure, and overall perspectives on living with HIV/AIDS.

### *Implications*

*Practice Implications.*—For gerontological practitioners, the results of this study can influence

practice approaches. Given the prevailing perspectives of successful aging, which emphasize avoiding disease and having high levels of mental and physical functioning (Rowe & Kahn, 1998), the lens through which practitioners view older adults often results in the medicalization of their situation. Particularly in a disease as serious and life threatening as HIV/AIDS, physical, virologic, and psychosocial deficits may take center stage. What we learned from these informants is that despite the seriousness of the diagnosis and consistent challenges with comorbidities, stigma, and depression (Emler, 2006b, 2007), these individuals exhibited resilience, finding strengths within themselves and their support systems to address the challenges of HIV disease. Practitioners should carefully consider the integration of a strengths assessment into practice strategies, thereby building on resilience and personal strengths in HIV-positive older adults.

**Research Implications.**—The findings of this study reinforce that older adults living with HIV/AIDS manifest strengths despite serious consequences of the disease. Our findings reinforce the importance of examining resilience in this population through a variety of research methods. Additional qualitative studies could further explore how characteristics of resilience and strengths are used in managing HIV disease. Quantitative studies could analyze subgroups that are more or less likely to employ resilience strategies in disease management and further explore the utility of the model by Kahana and Kahana (2001) to more fully understand the mechanisms that promote successful aging in these circumstances. These findings could lead to identifying at-risk individuals and developing interventions to enhance successful aging. Additional studies could develop and test potential instrumentation for assessing resilience in this population.

## Conclusions

This study contributes to the literature on resilience among older adults living with HIV/AIDS. By confirming the existence of resilient factors in this sample, the study affirms the relevance of resilience theory and the strengths perspective in this emerging line of inquiry. Further research with a primary focus on resilience using both qualitative

and quantitative methods will advance understanding of this important conceptual framework as it relates to aging successfully with chronic and life-threatening illnesses.

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