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Dimensions of the Fear of AIDS Scale among South African Students

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Abstract

Background: South Africa, with over five million people living with Human Immunodeficiency Virus (HIV), is the country with the highest number of people living with HIV. HIV transmission exploits one of the most complex areas of human life: sexual relationships. This in addition to its long asymptomatic phase and lack of imminent cure, have made it one of the most feared pestilence of our times. Youth in South Africa are particularly at risk of HIV infection. The **aim** of this study was to explore the structure of fears of Acquired Immune Deficiency Syndrome (AIDS) among students in South Africa using fear if AIDS Schedule (FAIDS) and test its cross-cultural validity with Australian and Nigerian findings. We **hypothesized** that the structure of fears of AIDS among Bellville, S.A. university students is similar to the structure of AIDS fears in Australian and Nigerian populations.

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Methods: The 38 item FAIDSS questionnaire was administered to a sample of 300 students in Bellville, Western Cape Province, South Africa. Data were entered, cleaned and analyzed using Statistical Package for Social Science (SPSS). The main statistical procedures performed were exploratory factor analysis, confirmatory factor analysis and internal consistency reliability.

Results: A five-factor structure (fear of loss of control, fear of sexual contact with groups perceived to have HIV, fear of sexual contact with outsiders, fear of infections, and fear of death and medical intervention) as found in the other study populations was replicated. All factors had internal consistency reliability of over 0.73 except fear of sexual contact with outsiders with alpha of 0.43. The factors were significantly correlated. Male subjects had significantly greater fear of infections while younger subjects had significantly greater fear of death and medical intervention ($p < 0.05$). The study demonstrates that the FAIDSS has cross-cultural psychometric stability, and that the dimensions of fears of AIDS in South African adolescents is almost identical to those in Australian and Nigerian samples. The cross-cultural stability of the FAIDSS makes it a potentially useful tool for evaluating the effectiveness and informational impact of HIV/AIDS prevention programs.

Introduction

About five million people were infected with Human Immunodeficiency Virus (HIV) during the year 2004, three million died from HIV related diseases and a total of 38.4 million were living with the virus (UNAIDS 2004). Over 64% of the people living with HIV are from sub-Saharan Africa, making it the hardest hit region, though having only 10% of global population. The prevalence of HIV across sub-Saharan African however varies widely. Southern Africa is the most severely affected with over 16% of the population being affected followed by East African countries with an average prevalence of 6%, West and Central Africa 4.5% and Northern Africa, less than 0.1% (UNAIDS. 2004). The UNAIDS (2004) report indicate that half of all new infection occurs among youth (15-24 years age-group).

South Africa has a distinction of being the country with the highest number of people living with HIV-5,300 000 as at the end of 2003 (UNAIDS 2004). The estimated prevalence of HIV in South Africa is about 12% (World Fact Book 2005, Pettifor et al. 2004, UNAIDS 2004). The youth and the sexually active age groups are disproportionately more affected by the epidemic. Among pregnant women the prevalence rate is estimated to be 25.4% (UNAIDS 2004). Other predictors of HIV prevalence in South Africa are age, gender, geographical region and the rural/urban divide (Kustner et al., 1998).

HIV and its sequel, Acquired Immune Deficiency Syndrome (AIDS), remains a major health priority of our times. HIV transmission exploits one of the most complex areas of our human life: sexual relationships. HIV prevention campaign demands that these relationships, whether conjugal, or illicit be brought out into the open and confronted. This in addition with

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its long asymptomatic phase, and lack of imminent cure, has made it one of the most feared diseases of our time. This fear of AIDS permeates every structure of our society: for each infected person there are additional families, friends, and co-workers affected (TIHAN, available at URL). It is thought that fear of AIDS may be the driving force in the individual and corporate response to the HIV pandemic (Sher 1989).

National response to the HIV pandemic is also shaped by the prevailing culture of fear of AIDS in the society. Uganda, hailed as a HIV prevention campaign success story, has achieved this distinction due to political leadership openness to accept the reality of HIV (Wendo, 2004; 506 Zuniga, 1999). The converse may be said of South Africa; one report on South Africa describes “social stigma associated with HIV/AIDS, tacitly perpetuated by the government’s reluctance to bring the crisis out in the open and face it head on, prevent many from speaking out about causes of illness and deaths of loved ones...” (*Guardian* newspaper Feb 11th 2005).

Responding to the epidemic will therefore require an appropriate response to the fear of AIDS. This should include a thorough understanding of the impact fear of AIDS has at individual and corporate level; on patients as well as their carers, and on those at high risk of infection like the youth. Understanding how fear of AIDS shapes societal response to HIV/AIDS is an important armamentarium in the design of targeted intervention programs, a feat that will be difficult to achieve without valid, reliable, and culturally competent measurement instrument. From the point of view of health counseling, counselors need to understand the bases of AIDS fears and how they may impact not only preventive behaviors of clients, but also how they may impact the response of family members who are affected. Distress accompanying AIDS concerns in both infected and affected individuals can be more effectively dealt with if health professionals are able to understand the bases of this distress. Further, if it can be demonstrated that the underlying dimensions of AIDS-related fears are similar across cultures, it allows us to use approaches that have been utilized in HIV/AIDS counseling and prevention in other countries with more confidence that they contain culturally-generalizable underlying dimensions.

There is paucity of studies on fear of AIDS in sub-Saharan Africa and the few available studies have used proxy measure of fear of AIDS such as attitudes and risk perceptions. In a survey among youth in South Africa, youth had positive attitudes towards people living with HIV (Pettifor et al. 2004). Studies of perceptions about AIDS among students in university residences in South Africa found that the levels of knowledge and awareness of AIDS among students was high (Friedland et al., 1990; Matthews et al., 1990). This was, however not matched by a corresponding degree of risk perception, nor has attitudinal change and appropriate knowledge led to adequate behavioral change.

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Several scales have been used to measure fear of AIDS (Waldner, 1999; Wang, 1997; Wang, 1996; Arrindell et al. 1989). The Fear of AIDS Schedule (FAIDSS), developed and tested in three western societies (Netherlands, United States and Australia) in 1989 (Arrindell et al. 1989), is the more widely used scale in measurement of fear of AIDS. Cross-national stability was established in a Nigerian study where the 5-factor structure was replicated (Akande and Ross 1994). However FAIDSS has not received a wide cross-cultural validation in sub-Saharan Africa, despite the widespread devastation of the continent by the epidemic.

This study was designed to explore the hypothesis that the structure of fear of AIDS among Bellville, S.A. university students is similar to the structure of AIDS fears in other populations. The findings of the study will be compared to previous studies carried out in Australia by Ross and Hunter (1991, 1992) and in Nigeria by Akande and Ross (1994).

Method

Study Population

The study was conducted in Bellville, a large urban city in the Western Cape Province, South Africa. The schools of higher learning (university, technikon, high schools, and secondary schools) where data were collected are located in low socio-economic neighborhoods that have high crime rates and considerable gang activity. The study subjects (N=300) were 14 years and older and represented an approximately equal number of black, white, and colored respondents. Some of the subjects were studying for a university entrance qualification.

Field procedure

Data were collected using a self-administered questionnaire. The questionnaire consisted of demographic section and a section on the 38-items fear of AIDS scale (FAIDSS). To solicit student participation, flyers were posted in school cafeterias, and one principal announced the study during morning congregation. Qualified students who volunteered to participate were asked to meet during their recess/break at the cafeteria. The students were informed that the research was intended to study South Africa's health issues and that the scale required ten to fifteen minutes to complete. Experienced research interviewers and trained teachers from the local schools carried out administration of the instrument. The teachers were not paid for the time they spent administering the survey. Participants were told that they could refuse to answer any questions, and that it would not affect their grades. Since subjects remained anonymous, the returning of the completed questionnaire was taken as evidence of consent. Confidentiality was stressed and identifying details (race, names) were not included in the questionnaire. The study was approved by the appropriate University of Texas Committee for the protection of Human Subjects.

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All completed questionnaires were collected from subjects, sealed in envelopes, and returned to the investigator for data analysis. Since this scale has been used on similar subjects in Australia (Ross and Hunter, 1991) and Nigeria (Akande and Ross, 1994) the subjects' fears of AIDS factor structure was compared to that of their counterparts in these countries.

Data analysis

Data were entered on Statistical Package for Social Sciences (SPSS^x) readable format for analysis on Personal Computer. The coding of questionnaire responses for the FAIDSS followed the published format. The evaluation of the FAIDSS consisted of three stages. In the first stage, validity issues were considered, by exploratory factor analysis employing principal components performed on the 38-items of the FAIDSS to establish whether the theorized factors were empirically supported. Following the exploratory factor analysis, confirmatory factor analysis specifying the five factors was conducted. The criterion estimation used was a maximum likelihood estimation followed by oblique rotation. Because cut offs of eigenvalues of >1 leads to overextraction, decisions were based on the scree plot to the maximum number of factors with three or more loadings greater or equal to 0.30 as suggested by Arrindell et al. (1989). The five-factor rotated matrix indicated that the results were equivalent to the exploratory analysis, with five principal factors giving eigenvalues significantly greater than 1. The exploratory factor and five-factor procedure therefore indicated equivalent emergent factors, providing concurrent validity for the theorized subscale factors designed in the scale.

Subsequent to the factor analysis, each of the five subscales were assessed for reliability using Cronbach's alpha coefficient as the criterion for internal consistency (Walkey, 1985). Overall reliability indicators were calculated on the survey, followed by the item scale reliabilities for each factor, and they ranged from 0.40 to 0.90. Together, these five factors accounted for 47.8% of the overall total variance. The third stage considered differences among the factors produced by factor analysis, by gender and age. To evaluate these differences a series of linear models were constructed and tested for significant differences.

Factor scales were computed and constructed by multiplying the item scores by the loading, and means and standard deviations were computed for each scale and compared across gender, and age was split into two groups at the median using *t*-tests. Finally, correlations were carried out between factors of fear of AIDS using Pearson product-moment correlation coefficients.

Results

Factor Structure

Table 1 reports the factor structure of fear of AIDS in the Bellville students. The first factor extracted by the factor analysis is described as a fear of loss of control factor. Fifteen items on the instrument were loaded on this scale, ranging from 0.45 to 0.76. The highest item to load on the scale was becoming mentally ill, followed by helplessness (0.71). The second factor is a fear of sexual contact with groups perceived to have HIV. Five items loaded on this scale, with factor loadings ranging from 0.61 to 0.75. The highest loading, 0.75, was intimate contact with prostitutes. The third factor is a fear of sexual contact with outsiders or stigmatized groups. Seven items loaded on the scale with factor loadings ranging from 0.33 to 0.76. The highest loading was extra-marital sexual contact, 0.76. Fourth is a fear of infections. Five items loaded on the scale, with loadings ranging from 0.49 to 0.66. Fear of contracting AIDS had the highest loading of 0.66. The final factor was described as a fear of death and medical interventions. Seven items loaded on the scale, with loadings ranging from 0.37 to 0.64. Taking medical tests and dying had the highest loadings.

Factor scores on the five factors by gender are presented in Table 2 and by age in Table 3. The only significant difference ($p < 0.05$) by gender was on the factor scale measuring fear of infections by gender; males had greater fear of infection. The only significant difference by age was on the factor scale measuring fear of death and medical intervention ($p < 0.05$); younger respondents showed greater fear. The lack of differences by gender and age further confirms the literature by Arrindell et al., (1989) that there is no significant variation across samples by gender or age.

Correlations between factor scores are presented in Table 4 and illustrate that the factor solution was moderately correlated and this correlation was significant ranging from 0.14 to 0.61. Significant correlations included Factor 1 with Factor 4 (0.61, $p < 0.001$), Factor 1 with Factor 3 (0.57, $p < 0.001$), Factor 1 with Factor 5 (0.44, $p < 0.001$), Factor 2 with Factor 4 (0.37, $p < 0.001$), Factor 2 with Factor 5 (0.43, $p < 0.001$), Factor 3 with Factor 4 (0.44, $p < 0.001$), and Factor 4 with Factor 5 (0.34, $p < 0.001$). Reliabilities of the five scales (Cronbach's Alpha) were Factor 1 (0.90), Factor 2 (0.74), Factor 3 (0.40), Factor 4 (0.77), and Factor 5 (0.73).

Discussion

The purpose of the study was to confirm the structure and reliability of fear of AIDS scale and cross-culturally. There are several interesting findings. The data indicate that there are five identifiable dimensions of fear of AIDS among Bellville students. These are fear of loss of control, fear of sexual contact with groups perceived to have HIV, fear of sexual contact with outsiders, fear of infections, and fear of death and medical intervention. The study also

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found that the factor structure is very similar to that obtained by Ross and Hunter (1991) of the FAIDSS in Australian health professionals, and Akande and Ross (1994) among Nigerian students except that the scales were extracted in different orders. The results both enhanced and substantiated the hypothesis that the scale as a measuring instrument does conform to its theoretical specifications and that it is a reliable measure of five variables pertinent to the fear of AIDS domain across several different cultures.

In the Nigerian and South African data, loss of control subsequent to AIDS disease was the predominant fear expressed by students. The similarity could be explained by strong socio-cultural characteristics of both study sites. Both Nigeria and South Africa are resource poor countries with low per capita income, low resources allocation to the health sector, and virtually no welfare support services for the terminally ill, elderly, and mentally ill. Thus, most people would naturally be concerned about the socially dislocating and disabling aspects of AIDS disease, about being mentally ill, hopeless and helpless if they contracted HIV. Furthermore, AIDS patients are also predisposed to losing their self-respect since in these countries the culture stigmatizes and blames people with AIDS, and also shows a considerable measure of social distance from them. By contrast, health professionals in previous studies were found to be more concerned about HIV infection through blood, a difference that is probably due to heightened occupational focus, health education and information dissemination in the health profession.

The fears of AIDS in this sample therefore should be interpreted in the context of both traditional and modern attitudes toward deformity and disability in South Africa and with the implication that the level of fear may be higher given the level of support and acceptance of the disabled. Stigma of HIV infection via sexual activity, with its echoes in the literature on STDs, produces some very thorny obstacles for HIV prevention and care. It further hampers AIDS prevention work on another level. Because of the implications of promiscuity, it is possible for partners also to use the threat of AIDS to impose such sexual codes as fidelity or monogamy onto each other. Finally the notion of sexual stigma, with its associations of guilt and blame, contributes to a culture of silence around AIDS. As a result, infected people are less likely to come forward for testing or possible care, thus reducing the likelihood of much-needed support and management of symptoms. Similarly, traditional attitudes in Nigeria and South Africa encourages able bodied dominance and a subservient role for those with disabilities within the society, and discourages the participation of people with disabilities in social, political, and economic activities.

Limitations

The results of this study should be accepted with some cautions for the following reasons. First, the subjects were a non-random sample of students attending schools of higher learning in Bellville, Western Cape, South Africa. Students attending these schools are usually privileged and are likely to be better educated than other adolescents. Findings, therefore,

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may not reflect the general trend about personal fears of AIDS in other regions of South Africa, particularly as the Cape region has one of the lower HIV seroprevalence rates in South Africa. The non-categorization of ethnicity is another limiting factor toward the generalization of the postulations substantiated in the study. Although social pressures may be the same for all students their cultural background and its influence on their perception of AIDS disease may differ. Secondly, since the study relied on self-reported questionnaires, and was administered by their own teachers, some students may have given socially desirable answers.

These data generated finding significant for several reasons. First, this type of study has not been carried out previously in South Africa. Earlier psychosocial studies have addressed AIDS knowledge but not fears about contracting AIDS. This study both establishes a baseline of students' personal fears about AIDS and provides an opportunity to repeat this type of study in the future to examine the change over time. Further, these data provide a means to examine fears about AIDS cross-culturally by comparison to previous and future studies. Such planning may aid in the planning of HIV prevention in South Africa, particularly intervention programs that target the adolescent avoidance of HIV exposure.

These findings confirm that a number of replicable and reliable dimensions of fear of AIDS exist in students, and that these cluster into five identifiable dimensions which could be helpful in assessing initial levels of fear about AIDS and determining changes over time in South African students. The clear comparability of the factor structure of FAIDSS in the present sample with previous samples enables direct comparison between fears of AIDS in other samples with similar population characteristics. Further, there were no differences on factor scores by gender and age, further confirming earlier reports in the literature that there is significant invariance across samples by gender and age. Factors in this sample suggest that the structure of fears of AIDS is relatively cross-culturally stable. Thus, a comparison of AIDS fears across cultures would appear to be possible.

Implications

These results have important implications for both counseling and for prevention of HIV transmission in South Africa. Our study implicates the fear of AIDS, especially loss of control as the main area of concern for Belville students. This concern is a reflection of the general traditional African attitude, which encourages able-bodied dominance and discourages participation of the disabled members of the society (Akande & Ross, 1994). Thus, in transferring technology as health pertaining to HIV in health care settings to third world countries, issues pertaining to cultural sensitivity must be addressed so as to ensure that such programs achieve their desired objectives. It has been established that the factor structures are stable in Australia and Africa; so many aspects of adolescent education programs in countries with similar populations may be designed with common elements.

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Fear is a motivator of attitude change in moderate amounts (Rigby et al., 1989; Ross et al., 1990), but in larger amounts may move people into denial. These data specifically identify the clusters of fears associated with HIV/AIDS, which in turn enables us to identify those which may be useful in prevention campaigns. Such campaigns might usefully concentrate on the negative aspects of HIV/AIDS using decisional balance (the pros and cons of changing risk behavior) in maintaining a person's preventive action. Further, controllability of infection and fears of infection can be placed in the hands of the individual. At a positive level, irrational fears of contact with people with the HIV virus, and xenophobia, can be minimized through accurate information. This scale may be a useful evaluation tool to determine the affective impact of HIV/AIDS education.

Counseling those infected or affected by HIV/AIDS needs to incorporate the underlying dimensions of the fear, rather than simply the fear itself, in order to understand which dimensions of the fear are rationally based and which are less rational. Counselors dealing with individuals who are attempting to deal with their own infection, that of significant others, and response to the stigma often associated with HIV, need to be able to deal with the actual sources of fear rather than the generalized response. Finding cross-cultural equivalence in measurement of fears of AIDS in South African adolescents compared with previous data from Australia and Nigeria allows counselors to assume that the bases of counseling interventions for fear of AIDS in one culture may be sufficiently similar to be useful in other cultures.

In conclusion, these data demonstrate that the FAIDSS has cross-cultural psychometric stability, and that the dimensions of fears of AIDS in South African adolescents is almost identical to those in Australian and Nigerian samples. The cross-cultural stability of the FAIDSS makes it a potentially useful tool for evaluating the effective and informational impact of HIV/AIDS prevention programs and for understanding the bases of HIV/AIDS-related fears in health counseling settings. The finding that the underlying dimensions of AIDS-related fears are similar to Australian and West African findings makes it possible to generalize health counseling approaches involving AIDS-related fears with greater confidence across these cultures.

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Bowers R. (2006), Wholistic applications of counselling with the aging in dialogue with pastoral care concerns: A postmodern and transcendental analysis, *Counselling, Psychotherapy, and Health*, 2(1), 68-85, April 2006.

Table 1: Factor Structure of Fear of AIDS in South African Students

FACTORS	ITEM	VARIANCE %	LOADING
Loss of Control	Attitudes	17.12	
	31	Becoming mentally ill	.76
	37	Hopelessness	.71
	38	Helplessness	.70
	36	Infecting others with one's illness	.69
	35	Loss of self-respect	.66
	20	Infection through blood	.64
	21	Infection through sexual contact	.63
	34	Becoming dependent on others	.59
	22	Infection through someone's illness	.57
	30	Inadequate (abnormal) behavior	.57
	29	Contact with blood of other human beings	.50
	28	Drugs or chemicals	.49
	33	Display of physical suffering of others	.45
	32	Becoming physically unattractive	.45
	25	Growing ill	.43
Fear of sexual contact with groups perceived to have HIV		8.40	
	12	No intimate contact with a prostitute	.75
	9	No intimate contact with bisexual men or women	.70
	7	Non-intimate contact with homosexual men or women	.70
	13	Physical contact with drug addicts	.61
	14	Physical contact with sick patients	.52
Fear of sexual contact with outsiders		8.37	
	15	Extra-marital sexual contact	.76
	17	Sexual contact with different partners	.75
	18	Frequent anonymous sexual contacts	.68
	11	Sexual contact with a prostitute	.59
	10	Sexual contact with bisexual men or women	.49
	8	Sexual contact with homosexual men or women	.33

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FACTORS	ITEM		VARIANCE %	LOADING
Fear of infections			7.17	
	1	Contracting AIDS		.66
	4	Contracting venereal disease		.66
	6	Viruses		.60
	3	Undergoing blood transfusion		.53
	2	Physical contact with a person with AIDS		.49
Fear of death and medical intervention			6.74	
	23	Taking medical tests		.64
	24	Dying		.64
	27	Death		.60
	16	Sexual intercourse		.53
	26	Foreigners		.44
	5	Getting an injection		.41
	19	Intimate contact with acquaintances		.37
Total Variance			47.81	

Table 2: Mean Differences on Factors of the FAIDSS between Genders

FACTOR	TITLE	MALES (n =)		FEMALES (n =)		t*	SIGNIFICANCE
		Mean	±S.D.	Mean	±S.D.		
	Fear of loss of control	54.35	11.99	53.53	12.96	.53	n.s.
	Fear of sexual contact with groups perceived to have HIV	11.04	5.12	10.96	4.56	.14	n.s.
	Fear of sexual contact with outsiders	23.84	5.89	23.68	6.37	.22	n.s.
	Fear of infections	17.48	5.12	16.34	5.18	1.84	p < .05
	Fear of death and medical intervention	17.27	5.70	17.13	5.74	.20	n.s.

*ns = not significant at p < .05 May need (n=) to enable readers confirm the t-tests?

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Table 3: Differences in FAIDSS Factor Scores in South Africa by Age

FACTOR	TITLE	YOUNGER		OLDER		t*	SIGNIFICANCE
		Mean	±S.D.	Mean	±S.D.		
1	Fear of loss of control	55.35	10.73	52.51	13.88	1.87	n.s
2	Fear of sexual contact with groups perceived to have HIV	11.14	4.57	10.84	5.00	.53	n.s.
3	Fear of sexual contact with outsiders	23.60	5.63	23.80	6.63	-.27	n.s.
4	Fear of infections	16.71	4.54	16.86	5.67	-.24	n.s.
5	Fear of death and medical intervention	17.94	5.70	16.48	5.69	2.15	p < .05

*ns = Not Significant at p < .05

Table 4: Inter-correlations between FAIDSS Factors

		FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4
FSC	Factor 2	.26			
FSCN	Factor 3	.57	.20		
FOF	Factor 4	.61	.37	.44	
FODMI	Factor 5	.44	.43	.14	.34

(All p < 0.001)