

Extrapunitive and Intropunitive Anger of HIV Caregivers: Nursing Implications

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The purpose of this qualitative study was to investigate the anger of individuals who have provided direct patient care to loved ones who are living with or who have died from AIDS. The sample consisted of eight individuals who are currently involved in an AIDS service organization in northeast Tennessee. Data were collected using semistructured taped interviews. At the beginning of the study, two group interviews were conducted. Subsequently, each of the participants was interviewed privately. Extrapunitive and intropunitive anger were predominant themes in each of the interviews. Participants also reported ways of coping with their anger. Nurses can suggest these strategies to other caregivers who are experiencing anger. Recommendations for additional nursing interventions are offered.

Key words: Anger, caregivers, HIV

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Acquired immune deficiency syndrome (AIDS) has engendered powerful emotions in infected people, their family and friends, and society at large. Along with anxiety, helplessness, sadness, and grief (Lippman, James, & Frierson, 1993), anger is a common reaction. People living with HIV infection have been the recipients of anger, hostility, and aggression. Dehumanizing and insensitive treatment by healthcare providers was reported by HIV-positive individuals in a study by Cavalaris (1987).

Ryan White, an HIV-infected adolescent hemophiliac, was labeled "faggot" even though he was heterosexual. A Florida family lost its home to arson because three hemophiliac sons were HIV-positive (Krauthammer, 1987; Voboril, 1987). Angry parents have picketed and blocked entrances to schools that permit HIV-positive children to attend (Plummer, 1987). Nurses and other professionals who provide health care for HIV-positive individuals have been objects of angry attacks. Loved ones of HIV-positive individuals also have endured angry rejections by family, friends, and acquaintances. Furthermore, caregivers of individuals with HIV infection may have angry feelings because of the stress and demands of their own difficult role. Little is known about the manner in which HIV caregivers experience and manage the anger related to HIV infection (Harvath, Patsdaughter, Bumbalo, & McCann, 1995). Therefore, the purpose of this qualitative study was to investigate how HIV caregivers experience and manage the anger related to this disease.

Review of Literature

Considerable confusion exists in the literature regarding terms such as irritation, annoyance, anger, hostility, and aggression. Drawing from the literature, clinical experience, and the results of her research, Thomas (in press) defined anger as "a strong, uncomfortable emotional

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response to a specific provocation that is unwanted and incongruent with one's values, beliefs, or rights. It pertains to events of greater significance than minor irritation or annoyance. It is less enduring and mean-spirited than hostility, and it is less destructive than aggression." Applying this definition to the present study, the unwanted provocation is HIV infection, clearly an event of great significance to all people involved with the care of a person living with HIV infection. The sequelae of the HIV diagnosis include many affronts to the values, beliefs, or rights of both the person living with HIV infection and his/her caregivers. The stigma of the disease is well documented (Alonzo & Reynolds, 1995; Baker, 1986; Carr, 1989; Des Jarlais, Friedman, & Hopkins, 1985; Eliason, 1993; Goldstein, 1990; Herek, 1984; Herek & Capitanio, 1993; Herek & Glunt, 1984; Phillips, 1994) and this stigma may be extended to all intimates of the person living with HIV infection (Lippman et al., 1993). Therefore, unlike caregivers of cardiac or cancer patients, families and friends of an HIV-positive individual also may be isolated. Costs of caregiving may include loss of employment, housing, and social support (Wardlaw, 1994).

Other potential outcomes of caregiving include significant physical and emotional stress (Turner, Catania, & Gagnon, 1994). Maintaining an intimate relationship with a loved one who is facing death is perhaps one of life's most difficult tasks. In a large study involving interviews with 642 HIV caregivers, Wardlaw (1994) found that caregivers provided substantial emotional support and comfort for HIV-positive individuals, and that most caregivers provided at least some help with activities of daily living. Because of the HIV-positive individuals cognitive or behavioral problems, one-third of the caregivers were attending to safety needs as well. Another difficult aspect of caring for someone with HIV infection is learning to tolerate the patient's anger, which is never an easy thing to do. One AIDS patient interviewed by McCallister (1991) admitted:

"When I first was diagnosed I had just an enormous amount of anger, and I took a great deal of it

out on my husband. It's like I almost waited for him to come home so I would have someone to yell at. . . . I think you take out a lot of your anger on those people that you love and you know love you, because they're a safe person to vent all that on" (p. 85).

It is logical to assume that excessive demands on caregivers' energy, strength, and resources eventually could produce considerable anger of their own. While this anger would be quite normal and justifiable, caregivers' health may be compromised if there is no available outlet for its expression. The effects of chronic anger are known to contribute to the etiology and/or progression of a number of physical and mental illnesses (Appel, Holroyd, & Gorkin, 1983). However, HIV caregivers may have discovered healthy ways to cope with their angry feelings. Therefore, the research questions for this study are (1) how and why are caregivers angry? (2) how do caregivers discharge their powerful emotion or channel it into productive action?

Methods

Design

Because this study sought to examine a complex human emotion, the researcher selected qualitative methodology. More specifically, a combination of focus groups and semistructured in-depth individual interviews was used to collect the data. Morse (1988) has pointed out that interviews encourage participants to tell their "whole story," rather than fragments predetermined by the researcher. Focus groups permit the researcher to obtain the viewpoints of many individuals in a short time, therefore they have become increasingly popular in health research (Polit & Hungler, 1995). The data were transcribed, coded, and analyzed using content analysis procedure. Categories were inductively derived from the data as described by Waltz, Strickland, and Lenz (1991) and Mishler (1986). The method outlined by Waltz et al. includes the following processes (pp. 301–307):

1. Define the universe of content to be examined
2. Identify the characteristics or concepts to be measured
3. Select the unit of analysis to be employed
4. Develop a sampling plan
5. Develop a scheme for categorizing the content
6. Develop explicit coding and scoring instructions
7. Pretest the categories and coding instructions
8. Train coders and establish an acceptable level of reliability
9. Perform the analysis

For this study, the universe of content included transcripts of the participants' spoken words and various written materials such as speeches, diaries, prose, and poetry. The phenomenon of greatest interest in this study was anger, and participants' words and phrases that revealed an experience of anger were the units of analysis in this study. Data were systematically assigned to categories. The coding procedures were pretested on the transcript of the first interview. Subsequently, the data were coded by one of the researchers, and coding was verified by colleagues in a qualitative research group. All words or phrases related to the experience of anger were classifiable as either extrapunitive or intropunitive. The findings were shared with participants in the study and validated. The findings also were validated by one caregiver (a nurse) who was not interviewed.

Sample

Participants were a convenience sample of eight adults who were providing (or had previously provided) direct patient care to an HIV-positive person (Table 1). Each of these caregivers was involved in a caregiver support group sponsored by an HIV service organization in northeast Tennessee. The unifying factor for group involvement was that each of participants was experiencing or had experienced the loss of a loved one as a result of AIDS. The group was heterogenous with respect to age, gender, and relationship to the HIV-positive person. Four women and four men participated in

Table 1. Description of the Sample

Participant Pseudonym	Gender	Relationship to PLWHIV	PLWHIV Pseudonym
• Marsha	Female	Sister	Fred
• Melissa (HIV+)	Female	Wife	Walter
• Beverly	Female	Mother	Stephen
• Jonathan (HIV+)	Male	Friend	Thomas
• Winifred	Female	Mother	Roger
• Ricky (HIV+)	Male	Friend	Michael
• Fred (HIV+)	Male	Partner	Trevor
• Jerry (HIV+)	Male	Friend	Mark

Note: Five of the eight caregivers were HIV+.

this study. The participant's relationship to the HIV-positive person included: wife, sister, two sons, three friends, and one partner.

Procedure

At the beginning of the study, two group interviews were conducted. Subsequently, each of the subjects was interviewed privately. Data were collected using open ended questions:

- (1) "Tell me about your experience with HIV infection."
- (2) "What were your feelings, your gut level feelings, when you found out that _____ has (had) HIV infection?"
- (3) "Are there any experiences that really stand out in your mind about taking care of _____?"
- (4) "If you had 20 minutes on television to tell the world about your experience with HIV infection and you could tell them exactly how you feel, what would you say?"

Participants were not limited to discussion of anger, but anger proved to be the predominant emotion.

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Whenever an emotion was expressed, the interviewer would say, "Let's explore that feeling a little further." As the study progressed, one individual shared a personal diary; other literary artifacts were subsequently presented to the interviewer and were included as data for the study.

Protection of Human Subjects

The rights of human subjects were protected by obtaining written consent and informing participants they could withdraw at any time without fear of retribution. A confidentiality statement prepared by the HIV service organization was signed by the interviewer. The names used in this article are pseudonyms.

Findings

Types of Anger

There were two broad categories of anger experienced by HIV caregivers: extrapunitive and intropunitive. Defining characteristics of each type of anger, and its basis, are summarized in Table 2. Extrapunitive anger was further classified into the following categories: (1) anger at the disease, (2) anger at the loved one with HIV

infection, (3) anger at other family members, (4) anger at desertion by friends, (5) anger at God and organized religion, (6) anger at society, (7) anger at the healthcare system, (8) anger at isolation standards and practices, and (9) anger at discrimination. Intropunitive anger was classified into the following categories: (1) blaming self for loved one's HIV infection, (2) blaming self for loved one's treatment choices, and (3) blaming self for loved one's sexual orientation.

Extrapunitive Anger

Anger at the disease. The metaphors used by the participants indicate the anger felt toward HIV infection. HIV infection is frequently referred to as the "enemy." Very seldom is the disease called HIV infection or AIDS. Metaphors used by these informants included the terms "the new leprosy" and "the plague." Most frequently, HIV infection is just called "it." Marsha, whose brother (Fred) is HIV-positive, expressed her anger at the disease: "It (HIV infection) was going to take my brother away from me. How dare this organism—whatever it is! How dare there be something we can't control."

Anger at the loved one with HIV infection. The caregiver frequently feels anger toward the HIV-positive loved one for contracting the illness. Marsha acknowledged that "I have anger at Fred (her brother) and Trevor (his partner) for putting themselves in the position of getting the disease. I was angry at Trevor—more than Fred. I think he gave it (HIV infection) to Fred."

Melissa, a woman who contracted HIV infection from her bisexual husband (Walter) says,

"I blamed Walter himself [sic] at first for getting it. It was about 2–3 weeks after I found out about HIV infection that I found out he was bisexual. It just blew my mind. I don't know if you could call me sane then or not. I don't think I was. I guess I was in shock and double shock. I guess if I hadn't been in shock and was sane, I don't know what I would have done when I confronted the other person. He just gave me the air like, 'Why, yes,

Table 2. Defining Characteristics of Extrapunitive and Intropunitive Anger

Type of Anger	Defining Characteristics	Basis
• Extrapunitive	Anger directed toward other people, society, and the disease itself	Disease Disruption Desertion Discrimination
• Intropunitive	Anger directed toward self	Guilt Blame Remorse Regrets

we have been together for years.' It was like it was no big deal. It may not have been a big deal to him, but it was like he tore a big chunk out of my life."

Anger also is expressed toward the loved one with HIV infection because the relationship is irrevocably altered. Marsha mourned the loss of her brother's support: "A lot of time I need support because of Fred (her brother). What am I supposed to do—call Fred and say, 'I'm afraid you are going to get sick and die. Help me feel better'?"

Anger at other family members. Anger is expressed toward family members who do not offer support. Marsha said, "I have been angry with my mother for not learning more about HIV infection—for not being more involved". Winifred revealed her anger toward her family for not being more supportive during her son's (Roger) illness when she said, "I was so aggravated with my family that I wouldn't even sit with them at the funeral home."

Beverly, a registered nurse whose son (Stephen) died as a result of AIDS, stated,

"Two nieces in my family outcast my son. It absolutely split our family apart . . . If you don't have anything to do with my son, you don't have anything to do with me! My mother got into the middle of it, and she wouldn't have anything to do with them either. It hurt bad. Not only emotionally, but the whole family."

Marsha said, "There are some people in my family who don't come to visit anymore."

Anger at desertion by friends. Jonathan, a caregiver for a close friend with HIV infection (Thomas), realized desertion in a very real way. Jonathan, a hair dresser, said,

"I was surprised with my business, with my customers. It just freaked them out. They gave no excuses—they made no explanations. They were

just gone. My business closed. I was in financial ruin. I lost my car, my telephone, and almost everything I ever had."

Jonathan and Thomas also were deserted by close friends. Jonathan reported "Most of Thomas's friends just stayed away, friends that he had for years. They would say, 'I just can't deal with this. I like Thomas; I love Thomas, but I just can't stand to see him this way.' They did not even communicate with him while he had AIDS."

Anger at God and organized religion. Marsha stated, "I was angry at God for letting it happen." Melissa (Walter's wife) expressed anger toward churches:

"And that deal with the churches. Don't get me started on that. I can't get over that. It looks like pastors would be more compassionate. If you go to church you keep your mouth shut about having HIV infection. My sister-in-law took it upon herself to ask the congregation if they would accept Walter [despite the fact] that he had HIV infection. And the congregation said, 'No.' They didn't want no part of it. I mean when the man was sitting in there with them, it was OK. As soon as he left and all of this was out in the open, and they knew what he had, they didn't want him back in there. Me and her (sister-in-law) got into a big uproar. I don't know how, but my fist wound up in her mouth."

Anger at society. Marsha expressed her anger toward society,

"Yes, because here was this disease and society wasn't doing a damn thing about it. Society was saying, 'Yeah, it's getting a few homosexuals and some heroin addicts.' The unspoken assumption was—good! Go ahead and get rid of them and we won't have to worry about them. Oh, God, it makes me very angry about it still. There are still some people who feel that these are people getting what they deserve."

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She was angry because "people are not involved" (in the fight against AIDS), "people put down those who are HIV positive," and "people do not care enough about themselves to stop their risk of contracting AIDS."

Anger at the healthcare system. Although not a predominant theme, anger was sometimes expressed toward the healthcare system. Jonathan stated, "When Thomas was in the hospital, there was a week that the cleaning people did not go into his room. His room finally reached the point that it became so dirty that his mother and I had to raise hell with the hospital."

A bigger problem for Jonathan was the hospital's breach of patient confidentiality:

"We had some trouble with Thomas' blood work. I would have thought that would have been kept confidential. I am a hair dresser—or was—for like 20 years. I had a business in my home. When they did his blood work, it was all over the hospital in a day that he had AIDS. Every customer I had quit. I mean just within a matter of two months. Everybody assumed that because he had AIDS—I had AIDS, too."

Anger at infection control practices. Infection control practices are commonplace in the hospital environment, but the meaning these practices have to patients in isolation is sometimes forgotten. The metaphors for the isolation paraphernalia were effective vehicles for expressing anger: "space suit," "moon suit," and "garb." Isolation apparel seem to embody the isolation that is felt. The lack of compassionate touch is a source of anger for both the HIV-positive individual and the family member providing direct care. HIV-positive individuals and their caregivers know that the use of gloves is required only when there is contact with certain body fluids. Winifred's son (Roger) wanted one of his friends to take off her glove and hold his hand. She refused. Winifred said, "It hurt real bad that she refused to touch him, but I didn't say anything." To be able to touch her son as he lay dying was important to Winifred. "They never asked me

to put on gloves or nothing. If they had, I would have told them where to take them."

Even though standards for infection control are written and placed throughout the hospital, these standards are not always uniformly carried out. Interview data suggest that this may be a source of concern and anger to the person being isolated, family members, and healthcare providers. Ricky (HIV-positive) stated, "Universal precautions don't bother me. I want healthcare workers to protect themselves. What irritates the hell out of me, however, is the inconsistency with which they are carried out."

Fred reported that the type of isolation used for an HIV-positive person is dependent upon which resident is on call. "Variously Trevor (his partner) would get admitted into respiratory isolation or just contact isolation or blood and body fluid precautions, which isn't isolation at all. You are supposed to do that anyway. And every time I would wonder what would be on the door the next time. I liked Melissa's approach. She just ripped her sign down and tore it into little pieces and threw it away."

Another example was shared by Beverly. She had some blood drawn for routine blood work. The laboratory technician did not wear latex gloves. When Beverly asked, "Are you not afraid of my blood?" the laboratory technician replied, "I'm not going to spill any." Beverly retorted, "How do you know that I don't have AIDS? I got real irate about the whole thing."

Anger at discrimination. People who provide care for HIV-positive individuals suffer discrimination for providing that care. Marsha was aware of discrimination at both a professional and a personal level. She related, "We (HIV service organization) had a lot of trouble finding an office space—just getting in here—which is awful. We had lots of people to refuse to rent to us." On a more personal level, she stated, "We have some friends who don't come to our house, and we aren't invited to their house any more since I have been doing this" (working with HIV infection).

Fred reported the following: "I heard one nurse say that she was receiving tremendous opposition from her family because she was taking care of people living with AIDS. They wanted her to come home and scrub, take a

shower in steaming hot water and wash with strong lye soap, before they would have anything to do with her."

Marsha stated, "I know someone whose lover is an occupational therapist who does not want her to work with people with AIDS. She even says that she doesn't work with PLWHIVs. But I know for a fact that she does. But obviously, in order to live with this person she has got to either not say anything or tell him that she doesn't work with PLWHIVs."

Intropunitive Anger

Blaming self for loved one's AIDS. Melissa, who contracted HIV infection from her bisexual husband, wrote, "I put a lot of the blame on myself. If I had been woman enough, he wouldn't have been out foolin' around and looking for other people. I put a lot of the blame on me that shouldn't have been there."

Blaming self for loved one's treatment choices. Marsha expressed anger at herself for her brother's choice of treatment options. She wrote,

"People got sick from the AZT as much as from the HIV, which Fred and I talked about. He decided that he wasn't going to take it, and I encouraged him not to take it. Sometimes I wonder now if that is why he can't take it. I wonder if he thinks of it as poison."

Blaming self for loved one's sexual orientation. Winifred blamed herself for her son's gay life-style. She wrote, "I was a Christian. I thought if I lived right this wouldn't happen. I was strict with my younguns [sic]."

The Management of Anger

Study participants described a variety of strategies that had proved useful in managing their anger. These strategies included: (1) writing poetry, (2) writing prose, (3) keeping a diary, (4) public speaking, and (5) writing politicians.

Writing poetry/prose. Mona, sister of an HIV-positive person, wrote a poem entitled "I Am Here." The following is an excerpt:

I am here...
unabashedly fueled by rage
acting up against my brother's murder
and the devastation our generation has acquired
asking: How long before we can rest the anger?

Douglas wrote a poem entitled "After So Long" to express his feelings about the loss of a loved one. The following lines are part of that poem.

how could this have happened
to the joy of my life entreating
to my favorite fantasy—
this dreaded deadly bite

Winifred found writing prose a way to express her anger and to share her story with her church. In "A Mother Who Has Been to Hell and Back," she wrote,

So mothers out there with sons and
daughters with this terrible
disease, no matter what their
lifestyles are, they are still our
sons and daughters. I happened to
love my son very much. If God would
have permitted him to live, I still
would be by his side, taking care of
him today. Instead, we have to lie
and keep it a secret in order for
our family to be protected.

Keeping a diary. Keeping a diary allowed Melissa to express her feelings without sharing them with others until the time was right to share those feelings. Melissa stated,

I already had a pistol and had it
loaded. I put it in my pocket book.
I thought, 'If he is not here, how are
you and the kids going to get along?
You and the kids just go with him.'
But, there before my eyes were my

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two children. It was just as plain as I'm looking at you. And they said, 'Mom, we've got our whole lives ahead of us. Please don't take that away from us.'

Public speaking. Many of the caregivers engaged in public speaking. Jerry, who had spoken to a group of medical students, said, "I would never have gotten up in front of that many people before this—especially doctors. Now, it seems as though I have something to say, and I have to say it." One of the medical students asked him in that meeting if he regretted his promiscuous life-style. Jerry retorted, "I don't recall having said that I led a promiscuous life-style. Sir, I am not a whore and never have been."

Writing politicians. Jerry found another way to deal with his anger. He said,

I've had to learn new ways of dealing with the death of friends; I've had to learn new ways to release that anger I feel about too little being done too late. Now I write politicians when I discover something I don't like and something I feel needs to be changed.

Discussion

Nursing Implications

These data suggest that both extrapunitive and intropunitive anger were commonly experienced by this sample of individuals who provided direct care to persons living with HIV infection. Feelings of extrapunitive anger flowed more easily than intropunitive ones. Intropunitive anger may be cloaked in expressions of guilt, blame, and regrets about what could have been. "What if" questions may signal the need to investigate intropunitive anger further. For instance, a parent's question might be, "If I had parented in a different way, would my son be gay and have this dreadful disease?" Study participants reported many strategies that assisted

them to cope with their anger. Nurses can suggest these strategies to other caregivers who are experiencing anger. However, supportive or crisis-oriented intervention by nurses may be indicated in addition to such self-care measures.

Nursing Process

The nursing process provides a useful framework for provision of care for the HIV caregiver (Table 3).

Assessment. Consistent with established principles of the nursing process, the first step in intervening with an HIV caregiver is a careful assessment. Careful observation of nonverbal behaviors and evaluation of the caregiver's words may reveal intropunitive or extrapunitive anger. Attributes of anger that must be assessed include its frequency, duration, intensity, and mode of expression. As Spielberger, Jacobs, Russell, and Crane (1983) have pointed out, anger has both a trait-like component (the person's general propensity to be hot-tempered) and a "state" aspect more specific to the present situational stimuli. Transient "state" anger provoked by the stimuli of everyday life results in a relatively brief psychophysiological arousal. However, chronic anger has cumulative effects such as higher blood pressure (Durel et al., 1989), anginal pain (Smith, Follick, & Korr, 1984), and coronary heart disease (Haynes, Feinleib, & Kannel, 1980). What is detrimental to physical and mental health is experiencing anger too frequently and intensely and/or handling it inappropriately (Thomas, 1993). Inappropriate anger-management methods include suppressing it, prolonging it through rumination, and somatizing the angry feeling through headaches, upset stomachs, and other physical symptoms. Some people unwisely choose to cope with anger and its unpleasant sensations through drinking, smoking, or drugs. More effective methods of expressing anger include vigorous exercise and talking to a trusted confidante (Thomas).

Nursing diagnosis. When the assessment is complete, a nursing diagnosis can be made. Differential diagnosis between several conditions is imperative. For instance, anger can be intermingled with *anxiety* about disease

Table 3. Application of the Nursing Process

• Assessment	Is the anger intropunitive or extrapunitive? What is the frequency, duration, intensity, and mode of expression of anger? Is the anger state or trait anger? What coping mechanisms are used? Are the coping mechanisms adaptive or maladaptive? Is somatization taking place? What are health consequences of anger in this caregiver? What are the predisposing factors?
• Diagnosis	Anger Anxiety Grieving Powerlessness Social isolation
• Plan	Mutual goal-setting Where, when, how will the intervention take place?
• Intervention	Establish a therapeutic relationship. Employ active, empathic listening skills. Help the caregiver to identify feelings. Assure the caregiver that his/her feelings are not wrong. Provide relaxation training. Provide assertiveness and anger management training.
• Evaluation	What was the anger experience? Was the anger intropunitive or extrapunitive? How was anger expressed? Was the mode of anger expression appropriate for the situation? Was the degree of anger expression appropriate for the situation? Have anger-related behaviors changed following interventions?

progression if the HIV-positive person is still living and by *grieving* if the person has died. For the HIV caregiver, powerlessness and social isolation may contribute to the experience and the expression of anger. The nursing diagnostic statement incorporates etiologic factors and

defining attributes. The following is an example of a nursing diagnostic statement: Inappropriate anger expression related to inadequate family support as manifested by yelling, screaming, and social withdrawal.

Planning. Planning helps to assure that nursing intervention will be effective. The most important part of the planning phase is mutual goal-setting. Together the caregiver and the nurse establish the outcome they would like to achieve. Next, it is important to consider which nursing intervention is most appropriate for this caregiver at this time. During this phase the nurse considers where, when, and how the nursing intervention will be delivered. Who will be present during the nursing intervention? For instance, if assertiveness training is employed, will only the nurse and the caregiver be present, or will the assertiveness training be conducted in a small group setting? The most important part of the planning phase is mutual goal-setting. Finally, the nurse needs to decide whether this is something that he or she can handle, or whether it is a situation that should be referred to another healthcare provider.

Intervention. The first step in the intervention phase is to establish a therapeutic relationship. Perhaps the most important principle of anger intervention with HIV caregivers is to establish a nonjudgmental climate in which they can talk about their angry feelings. It is not abnormal or sinful for them to be angry. Talking to an empathic listener can in itself be therapeutic; indeed, participants in this study affirmed that being interviewed for the research was a positive experience. Hutchinson, Wilson, and Wilson (1994) enumerated a variety of benefits of in-depth interviews, including catharsis, increased self-awareness, and healing. These benefits may be of even greater importance to individuals such as HIV caregivers who have been stigmatized or shunned and consequently have never been allowed to tell their stories.

Since caregivers may be unaware of the presence or the extent of angry feelings, the nurse helps them to identify angry feelings. Next the caregivers are encouraged to express angry feelings as they come into contact with those feelings. In the past 25 years popular media often have emphasized "ventilation" of anger (e.g., Bach

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& Goldberg, 1974; Rubin, 1970), but more recent sources point out that ventilation is not an unequivocal good, particularly if it is done in an attacking fashion (e.g., Lerner, 1985; Tavris, 1989; Thomas, 1993). Yelling, screaming, and other vehement expressions of anger not only cause substantial elevations of heart rate and blood pressure but result in damaged interpersonal relationships. For example, a caregiver with *extrapunitive* anger who yells at unsupportive family members may alienate them further. People with a high general propensity to be provoked to anger, or an exaggerated response once they have been provoked, may need to learn relaxation techniques. These relaxation techniques may be as simple as counting to 10 while breathing deeply and slowly or as sophisticated as self-hypnosis or guided imagery.

If the crux of caregiver anger is related to unfair or discriminatory treatment of their loved one by healthcare providers, assertiveness tactics can be introduced. Some caregivers feel powerless and inarticulate in the presence of doctors and other authority figures and do not know how to directly convey their concerns. Learning to make clear assertive requests may diminish this source of anger.

Some caregiver anger, particularly the *intropunitive* type, may be fueled by irrational thoughts. It is irrational for a caregiver to think that he or she could have prevented a loved one's sexual behavior or disease onset. Internalizing the stigma of AIDS also is irrational and damaging. Phillips (1994) defined internalized stigma of AIDS as "the extent to which the PLWA sees himself or herself as guilty, shameful, inferior, victimized, marked, dangerous, immoral, or evil" (p. 81). Internalizing the stigma of AIDS (Phillips) may be a source of *intropunitive* anger for either the PLWA or the caregiver. For instance, the caregiver may experience *intropunitive* anger for feeling shame about a loved one having HIV infection. Some caregivers may engage in health-damaging behaviors to punish themselves. Reframing, cognitive restructuring, and other cognitive therapies may be useful in combating guilt, remorse, and self-blame expressed by the caregivers.

Given the dismal prognosis of HIV infection at the present time, caregivers must face the likelihood that

death will take this person from them; the impending loss may rekindle pain and anger due to previous losses. Grieving these previous losses may not be finished. Emotionally laden issues from their families of origin or other prior relationships may be interwoven with the current anger about their loved one with HIV infection. Both *intropunitive* and *extrapunitive* anger can be manifestations of the normal grief process. Therefore, in grief and anticipatory grief counseling for HIV caregivers, it would be useful to investigate both types of anger through open-ended questions. Referral to a nurse psychotherapist or other mental health professional is indicated when anger is (a) extreme or chronic, (b) interfering with resolution of grieving, and/or (c) complicated by substance abuse or other self-destructive behaviors.

Evaluation. During the evaluation phase, the nurse considers changes in both anger experience and anger expression. The nurse returns to the assessment of behaviors that helped establish the diagnosis of anger and to the mutually established goals. Have these behaviors changed? Have the mutually established goals been met? In particular, the nurse should determine whether the method and the degree of anger expression was appropriate for the situation. How successful was the caregiver in identifying angry feelings? Did the caregiver successfully use coping mechanisms or interventions such as relaxation techniques?

Conclusion

The burden of stressors that is placed upon the person who provides direct care to a loved one with HIV infection is enormous. It is a burden that would try the strongest. However, all aspects of the caregiving experience are not negative. Caregivers may be heartened to know that Wardlaw's (1994) study showed that most people gained in self-esteem and strength from their caregiving experience. Nurses and other professionals who interact with caregivers must give them the support they need to enact their vitally important roles in ensuring compassionate and high-quality care for individuals with HIV infection.

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