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Measuring Psychosomatic Disorder in People Living with HIV/AIDS

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Abstract

Objectives- We assessed mental health status and knowledge of, being worried about AIDS.
Result- In our study on 17 HIV Positive persons in which 14 were male 3 were female shows 94.11% have shock,76.47% faces stigma, 70.58% faces discrimination, 47.05% faces family violence, 31.83% faces social violence, 41.17% faces family rejection, 64.70% faces social rejection, 88.23% goes in to depression, 76.47% feels loneliness, 100% persons feel fear, 58.82% have suicidal tendency.
Conclusion- Based on our review, we suggest that future studies should address the psychological needs of AIDS patients and develop health promotion programs to mitigate the negative impact of parental death on the physical and psychological well being of AIDS patients.

Key words: HIV/AIDS, Psychosomatic Problems**.**

Introduction

HIV & AIDS had a major impact on the social and psychological wellbeing of persons. There are many psychosomatic disorder faces by HIV/AIDS persons like stigmatization, discrimination, depression, social and family withdrawal, social and family violence, shock, various types of fear, loneliness, and suicidal tendency.

HIV/AIDS stigma devalues persons living with HIV/AIDS (PLHA) or those associated with them, and stems from underlying stigmatization of sexual behavior or intravenous drug use.[9] Discrimination, the 'unfair and unjust treatment of an individual based on real or perceived HIV

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status often follows. Manifestations include avoiding PLHA, passing judgment when determining their worthiness for health and social services, and applying cultural and structural sanctions.[1,2] Persons fearing viral acquisition may react negatively. Feeling disgust, anger, or contempt, they may intentionally or unintentionally discriminate to maintain a 'safe distance' from those they know or believe to be HIV+ve.[9]

For HIV/AIDS services to be effective, providers must understand their own prejudice and avoid discriminating against clients.[3,4] Still, because providers are often stigmatized and 'punished for their good deeds', many likely struggle with suppressing their own fears of instrumental and symbolic contagion.[5]

Such stigmatization can increase the adverse consequences of a disease in multiple ways. First, stigmatization can substantially increase the suffering of persons with the disease. Second, persons with or at risk for the disease may avoid seeking health care, making it much harder for public health authorities to control the disease. Third, professionals and volunteers working in the field may also become stigmatized, leading to higher rates of stress and burnout. Finally, stigmatization may generate considerable economic losses if people avoid groups or geographic areas associated with the disease.[6]

Violence against women is a substantial public health problem. Annually, at least 2.1 million women in the United States are raped or physically assaulted, and more than 10,000 rape victims and 79,000 assault victims require hospitalization. Women more commonly experienced violence during than after their pregnancy, but violence was best predicted by socioeconomic and behavioral indicators whose influence did not vary over time.[8]

Childhood sexual and severe physical abuse is associated with the following as adults: posttraumatic stress disorder, anxiety, depression, dissociation, substance abuse, re-victimization, high risk sexual behaviors and engaging in abuse of others. Approximately 1 in 4 respondents, regardless of gender, were sexually abused before the age of 13.[7]

Depression is a common condition experienced by people with chronic medical illness. It can be chronic and frequently disabling, affecting the course of medical conditions and hindering progress to recovery.

There was a high rate of self-reported depression in this group of PLWHA. There was Twenty-two per cent of the sample met criteria for a current Major Depressive Episode on the Inventory to Diagnose Depression (IDD).[11]

The nature of disclosure of HIV infection is processual and fluid and is not necessarily unilinear, sequential or with one inevitable outcome.

The 16 respondents who disclosed their HIV positive status to partners, 6 reported that they had experienced negative outcomes.[13]

16.6% women and 11.5% male faces negative outcomes following disclosure in form of blame, abandonment, violence, anger, stigma and depression .[12]

AIDS orphans in China were living in a stressful environment. Many orphans were struggling with psychological problems and unmet basic needs such as food, shelter, education and medical care. Experiences from African countries suggest that although the extended family might alleviate orphans' plight, it is unrealistic to assume that the children can escape from poverty without massive support from external sources. Relevant government agencies should develop a realistic and sustainable approach to ensure that the children's basic needs are met. National and international agencies should be approached to raise funds for orphans' education and vocational training. More importantly, orphans are strongly stigmatized and suffer from complicated grief resolution and other psychological problems. It is, therefore, essential to provide orphans and their caregivers with mental health services, including bereavement and grief counseling, transitional services and psychosocial support.[10,14]

Li et al; (2007); Claxton et al (1998), investigated factors associated with psychological distresses related to AIDS care; they reported that being younger, gay, male, better educated and employed were associated with a higher level of emotional exhaustion. Organizational factors, such as satisfaction with training, were positively related with personal accomplishment but negatively related with emotional exhaustion, depersonalization, anxiety, and depression.[15,16]

Method

A total of 100 consecutive individuals who attended VCTC clinic attached to the department of microbiology MLN Medical College Allahabad were taken as study material. All first time person of either sex and between the ages of 15-60 yrs were included for the purpose of the present study. Extremely debilitated persons, physically handicapped and those suffering from severe tuberculosis or leprosy were excluded for the purpose of present study. Persons who have already tested positive earlier were also excluded since their inclusion will affect the prevalence rate. The HIV test was carried out in the department of microbiology MLN Medical College Allahabad. The test was carried out for the second time after a period of 7-15 days. For the final confirmation of individual status the sample was collected for the western blot test. Our observations reported the result of the confirmed HIV positive cases only.
The study will include the high risk groups of our society exposed or affected by HIV/AIDS. The subjects of the study will be-

a. STD cases referred by STD clinic attending department of dermatology and venerology, SRN hospital, Allahabad.
b. Suspected/Resistant tuberculosis patient referred by department of TB and chest diseases, SRN hospital, Allahabad.
c. Clients referred by NGO's.
d. Cases referred by ART centre.
e. Those who are taking pre/post test counseling.

The target will be to screen as many cases from the above groups as possible by two rapid and

one ELISA test at the integrated counseling and testing centre (ICTC), dept. of microbiology, MLN Medical College, Allahabad, as per standard laboratory protocol.

All HIV positive persons expressed willingness to participate were included in the study. They were interviewed in line of-

a. Negative outcomes after disclosure of their HIV positive status like fear, stigmatization, discrimination, social rejection, family rejection, social violence, family violence, depression, shock, loneliness, suicidal tendency.

b. History of socioeconomic background- The person must be interviewed for their age, sex, monthly income, and occupation, migration from high risk regions like Mumbai, Surat, Chennai, and Kolkata. Person interviewed for their marital status, literacy status, and no. of children in the family. Personal habits like tobacco, alcohol, and other addictions and their family history.

c. Sexual behaviors- first exposure and age of starting of sex, their behavior like homosexual or heterosexual, groups/partners involved.

d. Knowledge about AIDS/STD and contraceptives especially barriers method.

e. Any other information like onset of illness, especially in case of STD or Tuberculosis must be properly evaluated.

f. Whether he/she has revealed his/her sexual partner. What was the response?

g. Change in social behavior of the HIV positive individual after he/she came to know his/her serostatus.

h. Change in his/her economic status.

i. His/her knowledge of the laws and rights of HIV positive individual.

j. His/her association with any NGO.

In 100 interviewed persons 75 were males and 25 were females. In 75 males 14 males were HIV positive and in 25 females 3 females were HIV positive.

Distribution of person suffering from psychosomatic disorder

Psychosomatic disorder	No. of person	% of person
shock	16	94.11%
stigmatization	13	76.47%
discrimination	12	70.58%
family violence	8	47.05%
social violence	5	31.83%
family rejection	7	41.17%
social rejection	11	64.70%
depression	15	88.23%
loneliness	13	76.47%
fear	17	100%
suicidal tendency	10	58.82%

Result

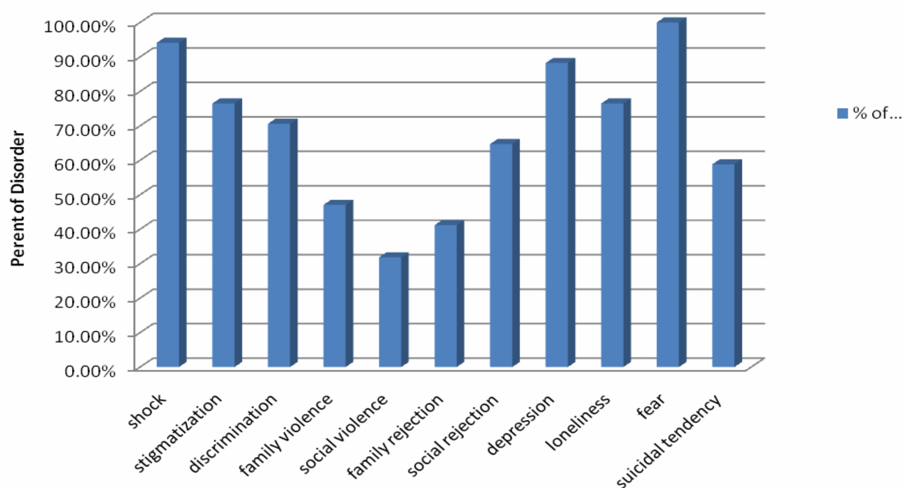
In total, from the VCTC clinic of department of microbiology of MLN Medical college of Allahabad, 17 HIV seropositive persons consented to participate in the study. In order to preserve confidentiality, it was not possible to obtain the detail of those who refused to participate in the study.

Sociodemographic data-The study sample was total 100 persons in which 75 were male and 25 were female. After screening the persons by 2 rapid and one ELISA test total 17 persons were found positive in which 14 were male and 3 were female.

The persons included in study mainly fall in between the age group of 15 to > 50 years and the majority of cases (approximately 35.71% male and 66.66% female) were found between the age group of 25-34 year.

In these 17 HIV positive persons 35% male and 100% female were found married and 78.52% male and 66.66% female were literate.
This study shows that 64.28% HIV positive male were unmarried this shows that unmarried male are more vulnerable to infection and inspite of higher literacy rate they are not aware for safe sex and use of condom.

Psychosomatic disorder data- in the given table we show the psychosomatic disorder in 17 HIV positive persons. The most common are fear 100% and shock 94.11%. Next to shock 88.00% persons have depression, 76.47% faces stigmatization, 76.47% feels loneliness, and 70.58% feel discrimination.
Violence more commonly occur in family (47.05%) as compare to social (31.83%) but the rejection mainly occur socially 64.70%. family rejection is 41.17%. some persons about 58.82% have suicidal tendency.



Different Psychosomatic Disorder

Discussion

The problem of HIV infection is growing at an explosive rate and this multifaceted problem has defied a medical cure till date. Thus, long term goals of combating this scourge comprise of integrated measures of prevention and rehabilitation of HIV infected individuals and finally to reintegrate them into the society Ministry of Welfare, social organization and community are basically concerned with prevention and rehabilitation aspects of these cases. Of course, an active co-operation and involvement of family members, relatives, and friends will take care of nervous breakdown, depression and suicidal tendencies which are more commonly encountered. Proper rehabilitation of AIDS patients is the crying need of the hour although it is a tedious and risky affair. AIDS patients are inadequately prepared for social integration owing to poor self-image and social stigmatization. They should be allowed to revaluate their goals and aims. Government, NGOs, social welfare organization, celebrities, sports personalities, cine stars, politicians should come forward in a big way for all-round awareness program for an effective containment against AIDS and should evoke AIDS charity appeal for the depressed lot. They should also propagate a drastic change in life style particularly in respect to sexual orgies. Government should provide HIV/AIDS patients the facility for time to time free testing of their blood samples. They also should have free insurance benefit. Cross infection in hospitals is a common event. It should be enforced by law for the hospital, where AIDS patients will be treated along with other patients, that, all precautionary steps are taken to prevent cross infection to the normal individual.[19]

Inter-sectoral coordination & involvement of non-governmental agencies might be needed to tackle the social, economical and other problems faced by HIV infected persons. All sero-positive individuals & their families should be provided with appropriate counseling in view of the fatal outcome of the infection & social stigma associated.[18]

HIV sero-positive women may elect to terminate their pregnancy and contraception or sterilization can be offered to them. Pre & post test counseling may educate pregnant women about methods to prevent HIV infection & its transmission.[20]

Continuous systematic changes in relevant laws in the form of deletions, alterations and/or additions, must necessarily cope with volcanic changes of fast development social environment including health hazards.

The concept of collective responsibility emphasizes that all of us, infected or not, low risk or high risk bear a responsibility to change our attitudes and behavior that may promote HIV infection.[17] besides both government & social organization should shoulder the responsibility.

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