

HIV: A Psychological Consequence

Miss. Sana Akhter¹

ABSTRACT

There are number of consequences of HIV/AIDS but in this paper reviews the literature on psychological consequences. HIV is a significantly related to Psychological problems like mental health problem, including substance-use disorders, depression and anxiety, post-traumatic stress disorder (PTSD), suicide and coping, cognitive disorders (including dementia), psychotic disorders, disorders of personality can influence behavior, memory disturbance, concentration problems and slowness of thinking as symptoms that are reported more often by individuals with HIV-related symptoms. People with HIV often suffer from depression and anxiety as they adjust to the impact of the diagnosis of being infected and face the difficulties of living with a chronic life-threatening illness, for instance shortened life expectancy, complicated therapeutic regimens, stigmatization, and loss of social support, family or friends. HIV infection can be associated with high risk of suicide or attempted suicide. The psychological predictors of suicidal ideation in HIV-infected individuals include concurrent substance-use disorders, past history of depression and presence of hopelessness. Treisman et al. claim that most HIV positive psychiatric patients actually suffer from multiple disorders. They classify these disorders into the following four categories, this appear in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). (i) Problems that Emerge from Life Circumstances, (ii) Brain Diseases, (iii) Personality and Temperament Disorders and (iv) Disorders of Motivated Behavior. HIV infection has direct effects on the central nervous system, and causes neuropsychiatric complications including HIV encephalopathy, depression, mania, cognitive disorder, and frank dementia, often in combination. Infants and children with HIV infection are more likely to experience deficits in motor and cognitive development compared with HIV negative children.

Keywords: *HIV/AIDS, Psychological Consequences, People Living with HIV/AIDS (PLWHA)*

AIDS the acquired immune deficiency syndrome is a fatal illness caused by a retrovirus virus known as the human immune deficiency virus (HIV) which breaks down the body's immune system, leaving the victim vulnerable to a host of life threatening opportunistic infections, neurological disorders or unusual malignancies. Among the special features of HIV infection are

¹ Research Scholar, Kolhan University, Chaibasa

HIV: A Psychological Consequence

that once infected, it is portable that a person will be infected for life. Strictly speaking the term AIDS refer only the last stage of the HIV infection (WHO, 2002).

HIV/AIDS is a global epidemic and it is a significant cause of death and disability. HIV Positive People have facing many psychological consequences. HIV is a chronic stressor that places HIV-infected persons as well as their immediate and extended families at risk for psychological distress and psychiatric disorders. Because patients and their families may have histories of substance use, chronic mental illness, poverty, physical abuse, violence, and isolation, they may have limited coping skills. Chandra et, al.(2015) state that HIV infection and psychiatric disorders have a complex relationship. Being HIV infected could result in psychiatric disorders as a psychological consequence of the infection or because of the effect of the HIV virus on the brain. Disorders may be as varied as depression, post-traumatic stress disorders, AIDS phobias, grief and the whole gamut of cognitive disorders. In addition, several psychiatric conditions may predispose individuals to acquiring HIV infection as a consequence of their influence on behaviour. There is also strong evidence of the relationship of substance use disorders and severe mental illnesses with HIV infection. HIV related psychiatric disorders also offer a challenge to clinicians in issues of differential diagnosis and management. Majority of the work in India has focused on substance use and HIV, and to a lesser extent on the psychiatric effects of HIV infection. Given the magnitude of the problem in the country and the multiple physical and psychological stressors that persons with HIV face in India, more research is needed. Because most patients with HIV and mental illness are seen in primary care settings, primary care practitioners are often the first to assess the risk of mental distress and to observe its signs and symptoms. These psychiatric disorders include:

- Mood disorders
- Substance use
- Personality disorders
- Adjustment disorders
- Cognitive disorders
- Depression
- Suicide risk
- Anxiety disorders

REVIEW OF LITERATURE

HIV/AIDS has no age-appropriateness and not even children are spared. In the Namibian context, an orphan is a child who has lost one or both parents or guardians to HIV/AIDS before reaching the age of 18, and who remains dependent (Sr. Mallmann, Catholic Aids Action, 2002).

HIV infections continue to increase rapidly among women, who made up 22 percent of cases in the U.S. in 1997 and now make up 42% percent of cases worldwide. (www.HIV+standard of women 2005).

HIV: A Psychological Consequence

There are a number of psychological impacts affecting children of HIV/AIDS parents. A parent who is HIV infected may show less interest in the child due to the dramatic mood swings associated with the pressure of being infected. The child usually does not know what the problem is, that it is not his or her fault, and does not understand why the parent seems moody. The child is likely to react with fear and anxiety and sometimes will blame themselves (Sr. Mallmann, Catholic Aids Action, 2002).

The psychosocial impacts of stress, grief, avoidance and teasing by other children, social isolation and discrimination can lead to behavioral disturbances, fatalism, self-stigmatization, and increased opportunities for abuse (Claudia Tjikuua, 2002).

Researchers have observed symptoms associated with trauma, depression and lack of bonding and attachment in very young children. This may lead to children feeling deprived of their childhood, causing misery and sometimes thoughts of suicide. Access to experiences which address psychosocial needs such as consistency of care appeared to be unmet for many children (C.K. Haihambo, 2004).

Many orphans are usually incorporated into the extended families that act as a safety net. However the shrinking number of caregivers and the considerable strain on families means that children are much more vulnerable to economic and social hardships such as malnutrition, poverty, child labour, homelessness and reduced access to education and healthcare (AIDS brief, 2004).

Low Beer et. al., (2000) found that as many as one half of HIV infected persons significant levels of depression making depression a particularly important factor in determining health and in HIV-infected women's evaluation of their health.

Voss et. al., (2007) fatigue and depression are among the most frequently rated symptoms of people with HIV/AIDS women experienced higher fatigue and depression severity scores than men.

PURPOSE

The purpose of this paper is to extend knowledge about HIV/AIDS and their psychological consequence such as: fear, loss, grief, guilt, anger, anxiety, low self-esteem, depression, suicidal behavior and thinking, and psychological disorder.

MATERIALS AND METHODS

The contents have been taken from relevant books and articles, research paper, forms journals and website. The method used is theoretical, and no practical work has done.

RESULTS AND DISCUSSION

“The psychological or internal challenges a person with HIV/AIDS faces vary from individual to individual. Not everyone will experience all of the emotional responses or stages of the emotional responses described. Each HIV/AIDS situation is as unique as the people involved. There are individuals who might face catastrophic changes not only in their personal and job relationships, but in their physical bodies and in their self-images and self-esteem.” (Watstein and Chandler, 1998).

Infected persons are normally in fear because they have to adjust to a new lifestyle. It is not easy to accept that one is infected and thus shock and disbelief, leading to denial, is a frequent initial response. According to Watstein and Chandler (1998) there are emotional responses that are symptoms of the psychological effects that people have when infected or affected with HIV/AIDS. Watstein and Chandler continue to explain that another destructive stressor is that of feeling dependent. The dependency occurs when the infected person must rely heavily on family and friends for emotional and financial support, particularly when they have to apply for social services assistance.

NEUROPSYCHIATRIC AND PSYCHOLOGICAL DISORDERS ASSOCIATED WITH HIV/AIDS

The World Health Organization asserts that the mental health consequences of AIDS are “substantial.”(World Health Organization) In addition to general emotional responses of “anger, guilt, fear, denial, and despair,” Lucia Gallego et al., (2000) 38 to 73 percent of HIV/AIDS patients will have at least one psychiatric disorder in their lifetimes,(Gallego, Gordillo and Catalan) with up to 20 percent of PLWHA exhibiting psychiatric symptoms as their earliest medical symptoms of AIDS(Robert A. Stern et al., -2000). Mental disorders associated with HIV/AIDS can result from the psychological impact of having a fatal disease, or stem from the effects of psychosocial stressors associated with the illness like stigma and discrimination. They can also result from actual neurological changes in the physical and chemical structures of the central nervous system that occur as a result of the HIV virus, opportunistic infections, or related treatments (Stern, Perkins, and Evans). Treisman et al. claim that most HIV positive psychiatric patients actually suffer from multiple disorders. They classify these disorders into the following four categories, described and elaborated below (Glenn J. Treisman-2001). Most of the disorders discussed in this section appear in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

1. Problems that Emerge from Life Circumstances
2. Brain Diseases
3. Personality and Temperament Disorders
4. Disorders of motivated behavior

1. Problems that Emerge from Life Circumstances

HIV/AIDS infected individuals face a number of the same stressors confronted by other patients with chronic illness, such as long-term discomfort, physical deterioration, physical and financial dependence and eventual death. These factors contribute to higher mental disorder prevalence among chronically ill people (30-50%) than among the general population (15-30%), (Gallego, Gordillo and Catalan) and suicide rates that are 7 to 37 times the rates of demographically comparable groups (Stern, Perkins and Evans). Disorders resulting from life circumstances may take the form of adjustment disorder, which is also known as demoralization. Demoralization has many of the same symptoms as depression, including sadness, feelings of helplessness, and sleep disturbances, but is treated through psychotherapy, not medication (Treisman, Angelino and Hutton). For HIV/AIDS patients, demoralization generally springs from the strain of chronic illness, social stigma, and the process of accepting mortality. Acute stress is also common for PLWHA immediately following an HIV positive diagnosis and as new symptoms develop (José Catalán, Adrian Burgess and Ivana Klimes,). In addition to emotional reactions, acute stress can lead to “somatic symptoms, suicidal ideation” and “substance abuse.” (Gallego, Gordillo and Catalan).

HIV/AIDS-related stressors can elicit high levels of anxiety among PLWHA. Anxiety may manifest itself through motor symptoms like shakiness and jumpiness, autonomic responses such as palpitations, excessive sweating, hyperventilation, rapid heartbeat, and diarrhea, or vigilance symptoms including hypervigilance, decreased sleep, irritability and distractibility (Warren and Stern, Anxiety Disorders). Anxiety can also be a symptom of other AIDS-related mental disorders like depression (Warren and Stern).

2. Brain Diseases

Neuropsychiatric disorders in HIV/AIDS patients are often overlooked since psychiatric are frequently misconstrued as psychological in nature (E. Koutsilieri, et al.,). However, actual neurological impairment can occur as a direct effect of HIV/AIDS on the central nervous system

(CNS) or result from opportunistic infections that the body is defenseless against due to immune system damage. 147,148 (Tiffany A. Chenneville and Howard M. Knoff-2004, F. Daniel Armstrong, John F. Seidel and Thomas P. Swales-1993) Brain diseases typically manifest themselves in syndromal forms and are caused by “structural or functional brain lesions” (Treisman, Angelino and Hutton). Autopsies reveal that three-fourths of all HIV/AIDS patients experience neurological changes, and 30 percent exhibit multiple lesions in the CNS (Stern, Perkins, and Evans). Examples of common, HIV/AIDS-related brain disorders include AIDS Dementia Complex (ADC), tumors, and opportunistic infections such as TB and cryptococcal meningitis.

3. Personality and Temperament Disorders

Treisman et al. cite two personality dimensions that are critical considerations in HIV/AIDS patient treatment. The first, stability-instability, looks at how patients react to and cope emotionally with stimuli (Treisman, Angelino and Hutton). For example, unstable patients are more likely to react to adverse situation with strongly negative emotions that may further compromise their health. In the second dimension, introversion-extroversion, extroverts “tend to seek rewards rather than avoid consequences” and “focus on the present rather than the future” (Treisman, Angelino and Hutton). Introverts, conversely, are more concerned with consequences. Though there are strengths and weaknesses associated with each trait, HIV/AIDS patients who tend toward instability and extroversion exhibit a higher level of risky behavior, have worse adherence to treatment regimens, and have more problems coping with the disease than their more stable, introverted peers (Treisman, Angelino and Hutton).

4. Disorders of motivated behavior

Research shows that 20 to 73 percent of HIV/AIDS infected individuals have substance abuse Disorders(Gallego, Gordillo and Catalan). In fact, transmission through injected drug use currently accounts for 5 percent of worldwide HIV infection(UNAIDS, “World AIDS Campaign 2001 Fact Sheet.”). For some, the mechanics of the substance use disorder (i.e.injection) or the impaired judgment and impulsivity associated with drug or alcohol use led to HIV infection. For others, substance abuse is a coping mechanism for dealing with an HIV positive diagnosis. It is critical that substance abuse disorders in the general population and among PLWHA be addressed since users are “prone to have sexual behaviors at risk for HIV transmission” due to “a higher rate of sexual dis-inhibition, impaired judgment, and impulsivity”(Gallego, Gordillo and Catalan).

Social support is an important determinant of health for PHAs (Borgoyne& Renwick, 2004; Richmond, Ross, &Egeland, 2007). Greater levels of social support have been shown to increase the number of visits a patient makes to a doctor’s office (Tamers, Beresford, Thompson, Zheng, &Cheadie, 2011), decrease stress, and increase physical (Moak&Agrawal, 2010) and mental health outcomes (Richmond et al., 2007; Bekele et al., 2013). Indeed, the availability of social support in PHAs is an integral part of achieving and maintaining optimal quality of life (Broadhead et al., 1983).

CONCLUSION

There are many Psychological Consequences of HIV/AIDS. Psychological interventions have been shown to increase the quality of life substantially for PLWHA (Catalan, 151-160).They can also play an important role in reducing the transmission of HIV by persons infected with the virus, especially adolescents and young adults. As antiretroviral medications become more widely used and prolong life for these young people, the risks of them handling life’s normal frustrations and disappointments inappropriately and deliberately exposing others to the infection

HIV: A Psychological Consequence

may also increase. With this in mind, developing culturally appropriate psychological interventions that target the young is critical. Such interventions could help them to cope better with their infection status, build the skills necessary for self-disclosure, and improve self-esteem. They should also address strategies for staying healthy with HIV, preventing future transmission, avoiding substance abuse, and moving forward with life (Catalan, 151-156). The interventions could be offered by primary care clinicians and others involved in the management of PLWHA (OyeGureje).

REFERENCES

- “AIDS Brief”, Nabcoa’s Quarterly Publication, 2004
- Bekele, T., Rourke, S.B., Tucker, R., Greene, S., Sobota, M., Joornstra, J., Monette, L., Reuda, S., Bacon, J., Watson, J., Hwang, S.W., Dunn, J., Guenter, D. (2013). Direct and indirect effects of perceived social support on health-related quality of life in persons living with HIV/AIDS. *AIDS Care*, 25(3): 337-346.
- Borgoyne, R., Renwick, R. (2004). Social Support and Physical Health. *SocSci Med*, 58(7): 1353-1266.
- Broadhead, W.E., Kaplan, B.H., James, S.A., Wagner, E.H., Schoenbach, V.J., Grimson, R., Heyden, S., Tibblin, G., Gehlbach, S.H. (1983). The Epidemiological Evidence for a Relationship between Social Support and Health. *Am J Epidemiol*, 117(5): 521-537.
- C.K. Haihambo, An Assessment of Services Provided to Children Infected and Affected by HIV/AIDS in Windhoek, Namibia, 2004
- Calvert Warren and Robert Stern, “Neuropsychiatric Emergencies in the Patient with HIV Infection,” *Emergency Medicine Reports* 16, no. 15 (24 July 1995), epidemiology.
- Catalán, José, Adrian Burgess and Ivana Klimes. *Psychological Medicine of HIV Infection*. Oxford: Oxford University Press, 1995.
- Catalan, Jose. “Psychological Interventions.” In *Mental Health and HIV Infection: Psychological and Psychiatric Aspects*. Edited by Jose Catalan, 151-163. London: University College London, 1999.
- Claudia Tjikua, “Impacts of HIV/AIDS on Education in Namibia”, Presentation speech by Chief Education Officer, 2002
- E. Koutsilieri, et al., “Psychiatric Complications in Human Immunodeficiency Virus Infection,” *Journal of NeuroVirology* 8, no. 2 (2002): 129.
- F. Daniel Armstrong, John F. Seidel and Thomas P. Swales, “Pediatric HIV Infection: A Neuropsychological and Educational Challenge,” *Journal of Learning Disabilities* 26, no.2 (February 1993): 93.
- Gallego, Lucia, Victoria Gordillo, and Jose Catalan. “Psychiatric and Psychological Disorders associated to HIV Infection.” *AIDS Reviews* 2, no. 1 (2000): 48-60.
- Glenn J. Treisman, Andrew F. Angelino, and Heidi E. Hutton, “Psychiatric Issue in the Management of Patients with HIV Infection,” *Journal of the American Medical Association* 286, no. 22 (21 December 2001): 2857.
- HIV+: standard of care: women (2005) www.HIV/women.htm
- Low-Beer, S., Chan, K., Yip, B. Wood, E., Montaver, J.S., O’Shaughnessy, M.V., & Hogg, R.S. (2000). Depressive symptoms decline among persons on HIV protease inhibitors. *Journal of Acquired Immune Deficiency Syndrome*, 23, 295-301.

HIV: A Psychological Consequence

- Moak, Z.B., Agrawal, A. (2010). The Association between perceived interpersonal social support and physical and mental health: results from the national epidemiological survey on alcohol and related conditions. *J Public Health*, 32(2): 191-201.
- OyeGureje, Professor and Head of the Department of Psychiatry University Of Ibadan, Nigeria, comments to authors.
- PrabhaS.Chandra, Geetha Desai* &Sanjeev Ranjan-2005, HIV & psychiatric disorders, *Indian J Med Res* 121, April 2005, pp 451-467.
- Richmond, C.A., Ross, N.A., Egeland, G.M. (2007). Social Support and Thriving Health: A New Approach to Understanding the Health of Indigenous Canadians. *Am J Public Health*,7(9): 1827 – 1833.
- Robert A. Stern, Diana O. Perkins, and Dwight L. Evans, “Neuropsychiatric Manifestations of HIV-1 Infection and AIDS,” in *Psychopharmacology. The Fourth Generation of Progress*, eds. F. E. Bloom and D. J. Kupfer. New York: Raven Press Ltd, 2000.
- S.B.Watstein, K. Chandler, *The AIDS Dictionary*. Facts on File, Inc.New York, 1998.
- Sr. Silke-Andrea Mallman, Building Resiliency Among Children Affected by HIV/AIDS,Windhoeck, Catholic AIDS Action Claudia Tjikuua,“Impacts of HIV/AIDS on Education in Namibia”, Presentation speech by Chief Education Officer, 2002
- Tamers, S.L.; Beresford, S.A., Thompson, B., Zheng, Y., Cheadie, A.D. (2011). Exploring the role of co-worker social support on health care utilization and sickness absence. *JOccup Environ Med*, 53(7) 751-757.
- Tiffany A. Chenneville and Howard M. Knoff, “HIV/AIDS: What Parents Should Know,” National Mental Health and Education Center, 1998, <http://www.naspcenter.org/adol_HIV.html> (14 August 2004), Neurological Implications.
- UNAIDS.“World AIDS Campaign 2001 Fact Sheet.”<http://www.thebody.com/un aids/pdfs/fs_wac.pdf> (20 August 2004).
- Voss, J. (2007.) symptoms cluster of fatigue and depression in HIV/AIDS Preventive intervention community, 33 (1-2), 19-34. Abstract
- WHO. (2002). AIDS watch, news from WHO SEAR on STD. AIDS and Tuberculosis, 5(1).
- World Health Organization. *Atlas: Mental Health Resources in the World*. Geneva: WHO, 2001