

**PSYCHOSOCIAL CONDITIONS OF INDIVIDUALS WITH HIV/AIDS IN MANIPUR****Nongmeikapam Premika Devi,****Assistant Professor,****Department of Clinical Psychology,****Regional Institute of Medical Sciences (RIMS),****Imphal (Manipur) Pin – 795004****Dr. K.S. Sengar****Additional Professor****Department of Clinical Psychology, RINPAS, Kanke, Jharkhand*****Abstract***

*The present study attempts to examine the relationship of depression, anxiety and coping strategies among HIV/AIDS infected males and females in Manipur. One hundred males and one hundred females infected with HIV/AIDS were interviewed and administered the Beck's Depression Inventory, Hamilton Anxiety Scale and Coping Check List. Results revealed no significant differences between HIV/AIDS infected males and females with respect to depression and anxiety. Coping by utilizing Social support has shown highly significant negative correlation with anxiety and depression which indicates that the more the person uses social support as coping strategies the lesser would be their anxiety and depression.*

**Keywords:** *Depression, Anxiety, Coping Strategies and HIV/AIDS.*

**INTRODUCTION**

The transmission of HIV in the region of Manipur is mostly through IDU. In Manipur, intravenous drug users are large in number and hence the prevalence rate of HIV/AIDS epidemic is high. The first HIV case in the State was found in 1989 in an IDU (Panda et al., 1994). The latest surveillance report of HIV infection in Manipur indicates that as on January 2011, of the 3, 93,006 individuals screened for HIV infection 31,256 were found to be HIV positive (MACS., 2011). In the North-Eastern region, particularly in Manipur, HIV infections are mainly found among injecting drug users (UNAIDS., 2004). Studies show that the geographical presence of IDUs correlates clearly with the path of the National Highway 39 in Manipur (Sarkar et al., 1995). This phenomenon of HIV/AIDS prevalence in Manipur cannot be blamed to a single cause. It essentially needs to be seen within the social, political, economic and cultural context of Manipur. The increase in unemployment rate combined with a highly westernised lifestyle of the youth exaggerated the HIV/AIDS epidemic in the State. General frustration, family problems, pleasure seeking, lack of societal control, and IDU as a fashion allowed intravenous drug use to emerge as a refuge for the restless youth. Along with this, poor health services, lack of political will and social unrest led to increase in the prevalence of IDU (Rajeev Irengbam, 2005).

Acquired Immune Deficiency Syndrome (AIDS) is a disease caused by a virus named Human Immunodeficiency Virus (HIV) and is characterized by immunosuppression, which leads to a spectrum of clinical manifestations that include opportunistic infections, secondary neoplasms, and neurologic manifestations. After gaining entry into a body, either through exposure to blood, body fluids, or sexual activity, the virus often enters a dormant stage lasting 2-15 years. The virus persists in the body for life and a person who is HIV antibody positive (Seropositive) is considered to be infectious. The clinical features of HIV infection range from asymptomatic infection to severe clinical illness and AIDS. The time for the onset of symptoms varies from five to six months to few years, and may be influenced by the source of HIV infection, age, gender, drug habits, immunogenetics, and other factors (Rajendran & Sivapathasundharam, 2006).

Persons who receive a diagnosis of HIV or AIDS often react with a mixture of emotions, including shock, depression, hopelessness, grief, anger and fear (Fleishman & Vogel, 1994). The complexities of stress have an effect on coping and psychological well-being (Russell & Smith, 1999). Solomon et al., (1993) found that HIV infected women had greater avenues of social support and used more socially based coping strategies whereas HIV infected men displayed more active coping strategies. Also another study by Simoni and Ng, (2000) have found that women with HIV/AIDS used adaptive coping strategies more frequently than avoidant ones, however other findings (Kaplan MS et

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al.,1997, Sherbourne C et al.,2003) have found that women used more maladaptive ways of coping than adaptive ways of coping. Also Hackl et al., (1996) has found that primary coping strategies most often employed by these women were denial, concealment of their health status from others, isolating oneself from others and crying.

Another study by Chandra et al., (2009) compared quality of life in men and women with HIV and found that men reported better quality of life in the environmental domain and women had higher scores on the spirituality/religion and personal beliefs domain.

A study by Ingram et al., 1999 and Benjamin O Olley et al., 2003 found no gender differences (HIV infected males and females) on depression and mood disorders. However multiple studies have firmly established the existence of higher rates of depression in women, twice as much as men (Bhatia & Bhatia 1999, Jones 2001, Simoni & Ng 2000, Greer 2001, Moore et al., 1999). A study by Swindells et al., (1999) provides evidence that social support can buffer deleterious health outcomes among individuals with HIV/AIDS.

## **MATERIALS AND METHODS**

### ***Sample***

The sample of the present study comprised of 200 HIV/AIDS infected males and females within the age group of 20 to 50 years residing in Manipur.

### ***Measure***

1. **A semi structured Performa** was designed to map the socio-demographic details.
2. **The Beck Depression Inventory-II (BDI-II, Beck et al., 1996)** is a 21 multiple-choice self-report inventory, one of the most widely used instruments for measuring the severity of depression. This test was used to assess the level of depression on HIV seropositive individuals. The test was also shown to have a high one-week test-retest reliability (Pearson  $r = 0.93$ ), suggesting that it was not overly sensitive to daily variations in mood. The test also has high internal consistency ( $\alpha = 0.91$ ).
3. **Hamilton Anxiety Scale (HAMA, Hamilton, 1959)** was one of the first rating scales developed to measure the severity of anxiety symptoms, and is still widely used today in both clinical and research settings. This test is selected to measure the severity of anxiety symptoms on HIV seropositive individuals. Internal scale consistency (coefficient alpha) has been found to be 0.92 and the mean item-to-total scale correlation was 0.65. The test-retest

reliability was 0.96 and the correlation between the computer and clinician HAMA scores was 0.92, providing support for the concurrent validity of the computer HAMA.

4. **Coping Check List (CCL., Rao et al., 1989)** was used to assess the participant's coping pattern. The CCL is a self-report inventory comprising 70 items, which covers a wide range of behavioural, cognitive and emotional response to handle stress. Items are scored dichotomously in a yes/no format, the responses indicating presence or absence of a particular coping behaviour. Further refinement of the tool resulted in 7 subscales: 1 for Problem Solving, 5 for Emotion focused coping (denial/blame, distraction positive, distraction negative acceptance and religion/faith) and 1 for socialsupport seeking. The test retest reliability (over 1 month) is 0.74 and the internal consistency is 0.86 as established by the authors.

HIV/AIDS infected individuals meeting the inclusion and exclusion criteria were selected from different ART centres located at Manipur. After obtaining written informed consent, all the participants completed the socio-demographic details, Beck's Depression Inventory, Hamilton Anxiety Scale and Coping Check List.

## STATISTICAL ANALYSIS

The data was than processed through SPSS Version 16 and Chi-square and Pearson Correlation test were applied wherever found suitable and interpretation was made accordingly.

## RESULTS

**TABLE - 1**

Gender-wise comparison of depression

Gender	Depression			Chi-square	d.f.	p-value
	Depressed	Not Depressed	Total			
Female	70 (51)	30 (48)	100	0.094	1	0.760
Male	68 (49)	32 (52)	100			
Total	138 (100)	62 (100)	200			

\*\* Correlation is significant at 0.01 levels

\* Correlation is significant at 0.05 levels

The above table no.1 shows the relationship of depression and the genders. Here female HIV patients (51%) have more depression when compared to male (49%) counterpart but the variation indicates no significant difference as evident by p-value = 0.760.

**TABLE - 2****Gender –wise comparison of anxiety**

Gender	Anxiety			Chi-square	d.f.	p-value
	Anxiety	No Anxiety	Total			
Female	57 (52)	43 (47)	100	0.504	1	0.478
Male	52 (48)	48 (53)	100			
Total	109 (100)	91 (100)	200			

\*\* Correlation is significant at 0.01 levels

\* Correlation is significant at 0.05 levels

It is observed from the above table no.2 that the female HIV patients (52%) have more anxiety than the male HIV patients (48%) but the variation shows no significant difference between the genders as evident by p-value = 0.478.

**Table No. 3.****Correlation between Coping Strategies, Anxiety and Depression**

Coping Strategies	Anxiety	P-value	Depression	P-value
Social Support	-.515(**)	0.000	-.187(**)	.008
Emotion Focused	.068	.337	-.002	.979
Problem Focused	.062	.062	-.054	.445

\*\* Correlation is significant at 0.01 levels

\* Correlation is significant at 0.05 levels

The above table no.3 highlights that social support has shown highly significant negative correlation with anxiety and depression which indicates that the more the person uses social support as coping strategies the lesser would be their anxiety and depression.

**DISCUSSION**

The findings shows that Females (51%) have shown higher depression than the males (49%) though statistical analysis have found no significant difference among them (p-value=0.760). Females (52%) have also shown higher anxiety than males (48%) but the variation shows no significant difference (p-value=0.478). This result is found to be consistent with the studies of Ingram et al., 1999 and Benjamin O Olley et al., 2003 where no gender differences (HIV infected males and females) were found on depression and mood disorders. However multiple studies have firmly established the existence of higher rates of depression in women, twice as much as men (Bhatia & Bhatia 1999, Jones 2001, Simoni & Ng 2000, Greer 2001, Moore et al., 1999). The finding of present study further shows the relationships of coping strategies, anxiety and depression. Statistical analysis reveals that

social support shows highly significant negative correlation with anxiety and depression which indicates that the more the person uses social support as coping strategies the lesser would be their anxiety and depression. These results are in line with findings from some previous studies where Ingram et al. (1999) found that people with more unsupportive social interactions related to HIV reported being more depressed significantly. Ashton et al., (2005) have also found that individuals with HIV/AIDS reported that social support were more likely to report lower increase in their HIV related health symptoms. Roger & Monica (2012) have observed that coping by avoidance and social isolation predicted more severe mental health outcomes. Spiritual and positive reappraisal predicted greater psychological adaptation than did social support seeking. Catz et al., (2002) have assessed anxiety, life stress, social support and coping on women with HIV and have found that greater anxiety and depressive symptoms were associated with women who reported higher stress, using fewer active coping strategies and perceiving less social support. Power et al., (2003) showed couple-based approaches enlisting partner support may help persons living with HIV to adhere to antiretroviral regimens. Along similar line Vosvick et al., (2004) have shown that greater assistance from friends was associated with greater sleep disturbances whereas greater understanding from friends regarding participants' HIV-related stress was associated with less sleep disturbances. The type of support from friends differentiated whether the support was positively or negatively associated with sleep problems. The findings of Koopman et al., (2000) indicated that HIV-positive persons who experience the greatest stress in their daily lives are those with lower incomes, those who disengage behaviourally/emotionally in coping with their illness and those who approach their interpersonal relationships in a less secure or more anxious style. A study by Remien et al. (2006) implies that interventions focused on improving coping self-efficacy, bolstering social support and decreasing stress in the lives of HIV-positive women may help to reduce the negative effects of HIV disease on mood. Using of maladaptive coping strategies to deal with the stress of living with HIV/AIDS, particularly engaging in various kinds of avoidant behaviours was significantly associated with greater depression at baseline and increased depression at three months (Gore-Felton et al., 2006). Moscovitz et al., (2009) determined that Direct Action and Positive Reappraisal were consistently associated with better outcomes in people coping with HIV across affective, health behavior, and physical health categories. In contrast, disengagement forms of coping, such as Behavioural Disengagement and Use of Alcohol or Drugs to Cope, were consistently associated with poorer outcomes.

The findings of the present study did not find any link between emotion focused coping and anxiety/depression but Mary kay et al., (1994) revealed that HIV infected individuals who used more emotion-focused coping experienced more depression.

Previous studies have found more rapid progression to AIDS associated with a greater number of cumulative stressful events, greater depressive symptomatology, and less social support (Ammassari et al., 2001 and Leserman et al., 1999). The use of particular coping strategies was also found to affect the level of stress and adaptation differentially. Coping by means of denial was associated with a more rapid progression to AIDS and higher levels of depression (Leserman et al., 1997), while problem-focused coping was associated with a higher quality of life (Swindells et al., 1999), the present study does not however find any link of problem focused coping and emotion focused coping with anxiety/depression. The findings provide further evidence that social support can buffer deleterious health outcomes among individuals with HIV/AIDS which is in line with the present finding where coping by social support decreases depression and anxiety. This shows the need for more social support among HIV/AIDS infected individuals to reduce negative outcome of the disease and to increase higher quality of life among them.

## CONCLUSION

Gender does not have any significant effect on the levels of depression and anxiety among HIV/AIDS infected individual which is supported by some previous study showing that gender has no role on depression and anxiety. The study further shows that the more the person uses social support as coping strategies the lesser would be their anxiety and depression. The present study reveals that enhancing the social support of individuals with HIV/AIDS will improved their psychological condition which draws the attention of mental health professionals and the society at large.

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