Psychological Problems Faced by Sero-Positive Women – A Review article

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Abstract

Introduction: Very few studies are available exploring the prevalence of psychological issues in seropositive women. Most of Human immunodeficiency virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) affected women are burdened with the responsibility of young, dependent children, and lack of community support. At the initial visit with the medical provider the women is most vulnerable to a number of emotions such as shock, disbelief, guilt, anger, sadness, and even suicidal ideation.

Objectives: The purpose of this article is to explore the psychological problems faced by sero-positive women.

Methods: Around 20 articles from various databases were analysed to reach the objectives of this study.

Results: Anxiety and depression were most encountered psychological issues related with seropositive women. Other issues like shock, disbelief, guilt, anger, sadness, and even suicidal tendencies were also noted.

Conclusion: Interventions are needed to decrease the impact of stress on sero-positive women so they can achieve a higher level of wellness, increase their life span, continue in the workforce, and improve their quality of life.

Key words: HIV-AIDS, Seropositive women, Psychological issues, Anxiety, Depression

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Introduction:-

We have witnessed the most dramatic improvements in women's health in human history. At every level, the quality of women's health care was enhanced and strengthened through advances in research, behavioural patterns, diet, pre- and post-natal care, new drug and surgical treatments, immunizations, to lead healthier lives. Socioeconomic concerns, such as poverty and issues related to violence, factor into our approach to women's health. Women face an array of psychological issues, related not only to

possible coexisting substance abuse, mental illness, domestic violence, and poverty, but also to the stresses of living with HIV disease and being the primary care provider for the family. Most HIV/AIDS-infected women are stigmatized. Most of these women are burdened with the responsibility of young, dependent children, and in general, lack of community support. Low self-esteem is the rule rather than the exception and plays a major role in ability to access and adhere to care.

Many sero-positive women often feel isolated and experience stigma and shame. Their roles as care givers and as wives and mothers are often changed or lost, and they experience anxiety and confusion about options for sexual activity. They sometimes fear transmitting HIV to family members through nonsexual contact.[1] They may feel anger at a partner who infected them sexually or guilt with a partner to whom they have been unable to disclose. Some of the emotional issues can be categorized at the time of encounter with the woman. At the initial visit with the medical provider the women is most vulnerable to a number of emotions such as shock, disbelief, guilt, anger, sadness, and even suicidal ideation.

HIV (Human immunodeficiency virus)

A type of viral infection that could progressively destroy the immune system was first suspected in 1981, in USA, The causative agent of AIDS is the human immunodeficiency virus (HIV).[2] HIV infections is characterized by three phases; 1) Acute Primary infection 2) Latent period, and 3) Chronic infection including development of symptomatic disease and eventually AIDS. Modes of Transmission of HIV: There are three basic modes of transmission.

(a) *Sexual transmission*

HIV/AIDS is first and foremost a sexually transmitted disease. Every single act of unprotected intercourse with an HIV-infected person exposes the uninfected partner to the risk of infection. The size of the risk is affected by a number of factors, including the presence of STD, the sex and age of the uninfected partner, the type of sexual act, the stage of illness of the infected partner, and the virulence of the HIV strain involved.

(b) *Blood contact*

AIDS is also transmitted by contaminated blood transfusion of whole blood cells, platelets and factors VIII and IX derived from human plasma. There is no evidence that transmission ever occurred through blood products such as albumin or hepatitis vaccines that meet WHO

requirements. Contaminated blood is highly infective when introduced in large quantities directly into the blood stream. The risk of contracting HIV infection from transfusion of infected blood is estimated to be over 95 percent. Since the likelihood of HIV transmission through blood depends on the 'dose' of virus injected, the risk of getting infected through a contaminated needle, syringes or any other skin-piercing instrument is very much lower than with blood transfusion. Needle sharing by drug users is a major cause of HIV/AIDS in the developed and developing countries.

(C) ***Maternal – foetal transmission: mother to child transmission:-***

HIV may pass from an infected mother to her foetus, through the placenta or to her infant during delivery or by breast – feeding. In the absence of any intervention, rates of this transmission can vary from 15- 30 percent without breast feeding and reaches to as high as 45% with prolonged breast feeding. Transmission during the peripartum period accounts for 1/3rd to 2/3rd of overall numbers infected and this period therefore becomes a focus of prevention efforts. Transmission of HIV from mother to child can be prevented almost entirely by antiretroviral drug prophylaxis, elective caesarean section before onset of labour and by refraining from breast feeding.[4] There is no evidence that HIV is transmitted through mosquitoes or any other insect, casual social contact with infected person including within household, or by food or water. There is no evidence of spread to health care workers in their professional contact with people with HIV/AIDS.[5]

Incubation period:-

While the natural history of HIV infection is not yet fully known, current date suggest that the incubation period is uncertain. It may take few months to 10 years or even more to the development of AIDS from HIV infection however it is estimated that 75% of those infected with HIV will develop AIDS by the end of 10 years. [6,7] Current recommendations include "Health – care providers should ensure that all pregnant women are counselled and encouraged to be tested for HIV infection to allow women to know their infection status both for their own health and reduce the risk of perinatal HIV transmission."[8]

Confidentiality: Confidentiality is a key issue in HIV/AIDS testing. No person should be given an HIV/AIDS test without his or her knowledge and consent.

Confidentiality * Important to safeguard the rights of HIV infected.

* To prevent victimization, ostracisation, discrimination, etc.

* Some kind of code should be devised to indicate the HIV-Positive status. "HIV-POSITIVE" words should not be written on the case sheet.

Consent: Consent is only valid when it is given freely by a patient who understands the nature and consequences of the proposed tests. This requires adequate pre-test discussions of these issues (counselling). Consent is particularly important for HIV testing because of possible serious social, financial and personal consequences.

Counselling:Counselling is an important aspect of HIV testing. Whenever the result of HIV testing is going to be linked to an individual, counselling plays an important role. The aim of pre-test counselling is to provide information on the possible impacts relating to personal, medical, social, psychological, and legal aspects of HIV test results, whether it is HIV-positive or HIV- negative. In the screening, the rights of individual must also be recognized and respected. A relationship is established with the patient as a basis for post-test counselling. Post –test counselling should always be done without fail and the HIV test result is communicated to the patient directly (one to one interaction). [9, 10] The principle aim is to understand the test result and initiate adaptation to their sero-positive or sero-negative status. It is done in most confidential form and the result is disclosed only to the patient.

- **Seropositive women through epidemiological perspective:-**

Although the overall prevalence of HIV is below 1%, due to the large population size, India has a large number of people living with HIV/AIDS, second only to South Africa. The national adult HIV prevalence is 0.8% with HIV prevalence rate of above 1% among pregnant women.[11] Women make up twelve percent of the AIDS cases in the United States. [12]

Male to female prevalence ratio changed over period of years since 1982. According to an epidemiological bulletin, 79,814 cases of AIDS in women have been reported since 1982.[13] Various studies have estimated the lifetime prevalence of depression in women to range from 22% to 45%. [14] A meta-analysis of ten studies comparing the prevalence of depression in HIV-positive individuals to that seen in HIV-negative individuals concluded that the infected individuals were diagnosed with major depression 1.99 times more often than were uninfected individuals. [15] In a study evaluating the prevalence of depressive disorders over the course of the disease and consequent onset of symptoms in women with HIV, out of 120 (60

symptomatic and 60 asymptomatic) The prevalence of major depression was 25.8% and was higher in the symptomatic group than in the asymptomatic group[16]

Psychological issues:-

Women face an array of psychological issues. Kubler Ross staged model of responses to death and dying is a good starting point to think about some of the emotions experienced by persons who are living with HIV. Kubler Ross identified five progressive phases: denial, anger, bargaining, depression and acceptance. [17]

Common Psychological Issues Experienced By Sero-Positive Women.

Shock & Disbelief*:* These are the expected reactions on confirmation of HIV-seropositive status. Person will be seen in the state of total loss of control, breakdown or emotional withdrawal.

Denial*:* Response to sero-positive status is sometimes seen in the form of denial. The denial can become counterproductive as the patient will refuse to accept the result and as a consequence of it person will refuse to accept the social responsibilities that go along with being HIV-positive.

Guilt**:** Guilt is related to the feeling of sadness relating to how she may have been the cause of illness in her own family, particular her children. And the diagnosis of HIV-seropositive status provokes the feeling of guilt over the possibility of infected others.

Loss*:* The news of HIV positive result will create the feeling of loss of financial stability; fear of losing the job will become stronger. Independency will be at risk as person will start losing confidence in her.

Anger*:* Anger towards the partner, who infected her and anger is directly sometimes manifested in the form of self destruction.

Positive approach*:* Some patients think, GOD will cure them if they stop sex.

Relationship conflicts: Confirmation of the news of HIV-seropositive status will lead to relationship conflicts. For a married woman her partner's infidelity may for the first time be made undeniable. The confrontation of these facts within the family unit may be very destructive.

Fear: As to social threats, the stigma of HIV–positive and discrimination of people with HIV has not disappeared, subsequently person with HIV-sero-positive status will fear aloneness in terms of being abandoned and isolated , thereby creating a sense of invisible i.e. to experience psychological death creating the fear of dying and particularly dying alone with pain.

Anxiety*:* Anxiety reflects the chronic uncertainty associated with the HIV-seropositive status. Anxiety may be

manifested in the form of undiagnosed agitated depression; substance abuse or use, side effects of prescribed or over the counter medication, a psychotic or manic disorder, undetected infections. Anxiety as a symptom may range from a mild sense of dread or unease to full-blown panic attacks with sweating, palpitation, dizziness, extreme agitation, decreased sleep, irritability and distractibility.

Depression: Depression may arise due to the absence of cure and the resulting feeling of powerlessness, loss of personal self esteem and the loss of personal control that may be associated with frequent medical examinations. Episodes of depression are twice as common in HIV seropositive patients as they are in general population. [18]

Symptoms of Depression

* Persistent sadness, anxious, or "empty" mood
* Feelings of hopelessness, pessimism
*Feelings of guilt, worthlessness, helplessness
*Decreased energy, fatigue, being "slowed down"
*Difficulty concentrating, remembering, making decisions
* Insomnia, early-morning awakening, or oversleeping
* Appetite and/or weight changes
* Thoughts of death or suicide, or suicide attempts
* Restlessness, irritability

If five or more of these symptoms are present every day for at least two weeks and interfere with routine daily activities such as work, self-care, and childcare or social life, the patient must be evaluated for depression. [19, 20]

Suicidal thinking: Suicide is seen as better way of avoiding pain and discomfort or of lessening the shame and grief of loved ones. Patients with the HIV sero-positive status, particularly with advanced HIV diseases have a thirty-fold risk of committing suicide compared to sero-negative persons. More recent studies have shown a risk for suicide in patients with HIV disease at all phases of HIV infection. [21,22] Advances in therapy may heighten hope and reduce the risk of suicide.

Sleep disorder: Decreased sleep quality, difficulty falling asleep, fragmented night-time sleep and early morning awakening seem to increase as immune function and CD4+ lymphocyte counts diminish, and they may affect a substantial proportion of patients with HIV/AIDS.

Neurocognitive disorders: Presently the neuro-cognitive complications can be classified as two syndromes differing in level of severity;

1. HIV associated mild neurocognitive disorder (MND) &

2. HIV associated dementia

Mild Neuro-cognitive Disorder (MND)

A person present with some difficulty in concentrating may experience easy fatigability when engaged in demanding mental tasks, may feel subjectively slowed down, and may notice difficulty in remembering. Such patients may complain that they are not as sharp or as quick as they once were. Such complains especially of younger patients, who may be struggling to accept their sero-positive status, may lead the clinician to conclude that anxiety, depression or hypochondriases are responsible. It is important to notice that these Mild Neuro-cognitive deficits occur independently of depression, anxiety, and other non HIV sources of cognitive deficit.

HIV Associated Dementia

The cognitive abnormalities in patients with dementia are more profound and more generalized than in patients with mild neuro-cognitive deficits. The patient complains of severe forgetfulness, difficulty in concentrating, problem in finding words and framing sentences, marked mental slowness and disorientation. As the dementia progresses, the patient condition becomes more pathetic with severe disorientation and confusion persists and may have difficulty with independent living.

Delirium: Delirium is a serious complication related to HIV seropositive status. The causes of delirium include CNS opportunistic infections, drug toxicity, systemic illness and primary functional disease related to disorientation and confusion.

Psychotic disorders: Psychotic symptoms are late stage complications of HIV infection. Medical persons are aware of the facts that medications may cause psychosis and hallucinations include anabolic steroids, amphotericin, anticonvulsants, ciprofloxacin, corticosteroids, dapsone, ganciclovir, H-receptor antagonists, ketoconazole, non steroidal anti-inflammatory agents, metronidazole, salicylates, sulfonamides, zidovudine.

Conclusion:-

At the time of diagnosis with HIV/AIDS women immediately see themselves differently and their behaviour will change towards life initially they will be in the state of denial or shock & disbelief. The purpose of this article is to explore the multidimensional effects on the personality of women. The behavioural changes of person due to HIV/AIDS affects access to health care, medication adherence, social interaction, and social support. Interventions are needed to decrease the

impact of stress on sero-positive women so they can achieve a higher level of wellness, increase their life span, continue in the workforce, and improve their quality of life.

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