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Trauma And Mental Health Of Hiv Positive Persons

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Abstract: This paper aims to review the studies conducted on the victims of HIV/AIDS in the form of trauma and its implications on mental health on patients. It also emphasizes, how traumatic and mentally ill patients with HIV/AIDS respond to various types of interventions. With this in view, previous research studies, available literature and reports were explored and reviewed to ascertain and conceptualize traumatic and mental health conditions of the HIV/AIDS patients. It was inferred that sexual exploitation, abusive behaviors, physical and mental tortures, social insecurities and liabilities, etc lead to anxiety, depression, tension, feelings of insecurity, hopelessness, poor health, etc. vis-a-vis poor mental health among the HIV/AIDS infected persons. Thus, along with the medical and pathological interventions psychosocial interventions are also required in treating people living with HIV/AIDS.

Keyword: Trauma , Mental Health , Hiv Positive , HIV/AIDS .

INTRODUCTION:

According to UNAIDS (2007), the population living with HIV was estimated at 33.2 million through out the world in the year 2007, further it also reported 2.1 million deaths due to AIDS. At the end of 2011, about 34 million people currently living with HIV, 2.5 million peoples are newly acquiring HIV/AIDS and about 1.7 million people have died of AIDS-related causes (UNAIDS, 2012).

In comparison to the general population, Individuals living with HIV often have complicated histories including negative experiences such as traumatic events, depression, anxiety and stress. Based on the research studies/ literature available in this article an effort has been made to identify the extent and types of trauma and psychological factors as they related to HIV/AIDS: such as traumatic events, depression, anxiety and stress among individuals with HIV disease. These factors have been found to be prevalent among individuals with HIV/AIDS and have been associated with poor health outcomes. An attempt also has been made to highlight, how trauma and mental health are related to health behaviors including adherence to medication regimens and HIV risk behaviors such as unprotected sex and needle sharing.

TRAUMA AND HIV/AIDS

People, who have unresolved trauma, are prone to repetition compulsions and may unconsciously re-enact their traumatic experiences. Studies illustrate that a history of trauma is quite common among HIV positive than the general population. Kelly et al. (1998) reported that post traumatic stress disorder-HIV was related to other psychiatric diagnosis, particularly the development of first episodes of major depression after HIV infection. Post traumatic stress disorder-HIV was significantly related to a pre-HIV history of post traumatic stress disorder from other causes, and other pre-HIV psychiatric disorders. Kimerling et al. (1999) illustrates that HIV infected women were significantly more likely to report a victimization experience. Furthermore, among the respondents, victims reported higher levels of global psychological distress, depressive symptomatology and greater distress regarding physical symptoms than nonvictims. Hutton et al. (2001) highlighted that age, education, race, HIV status and addictive disorders, a lifetime occurrence of post traumatic stress disorder was related to the practice of anal sex and prostitution. Kalichman et al. (2002) indicated that sexual assault survivors reported greater anxiety, depression and symptoms of average personality were significantly more likely to report recent unprotected intercourse than persons who had not been sexually assaulted. Martinez et al. (2002) found that the level of post traumatic stress disorder was significantly associated with the number of life events experienced and to perceived social support from friends and family. Smith et al. (2002) illustrates that HIV positive individual with post traumatic stress disorder report higher levels of physical pain. In a study conducted by Sebit et al. (2003) found that more than two third of the respondents suffered from psychiatric disorders in addition to having a higher prevalence of alcohol use / misuse.

A study of individuals with a new HIV diagnosis in South Africa highlighted that women and history of sexual abuse were related to a post traumatic stress disorder diagnosis (Olley et al., 2005). Olley, Seedat, Stein (2006) found that 56% of patients had at least one psychiatric disorder at baseline, and 48% of patients had at least one psychiatric disorder at 6 months and also highlighted that depression and post traumatic stress disorder were the most common disorders at both baseline (34.9% and 14.8%) and follow-up (26% and 20%), respectively. Mugavero et al. (2006) reported that the number of categories of lifetime

traumatic events, the addiction severity index alcohol score and being uninsured were related to antiretroviral nonadherence. Whetten et al. (2006) found that statistically significant decreases in participants psychiatric symptomatology, illicit substance use, alcohol use and inpatient hospital days. Whetten et al. (2006a) highlighted that around one third of the respondents experienced lifetime sexual abuse. More than half of the respondents experienced sexual or severe physical abuse by the time of the interview. Gender was significant only when controlling for sexual orientation. Women and non-hetrosexual men were more than twice as likely to have experienced both forms of abuse. Pence et al. (2007) found that more than half (54%) of them had probable psychiatric disorders, 30% of the people having history of childhood sexual and 21% of them had an experience of physical abuse. A study conducted by Leserman (2008) illustrates that significant and consistent evidence that chronic depression stressful events and trauma may negatively affected HIV disease progression in terms of decreases in CD4 count, increases in viral load and greater risk for clinical decline and mortality.

Adewuya et al. (2009) reported that 61.6% of the respondents had experienced or witnessed a stigmatizing event related to HIV status. Logie and Gadalla (2009) pointed out that high stigma level was significantly related to low social support, poor physical health, poor mental health, age and income. Melander and tyler (2010) indicated that sexual abuse is directly linked with street sexual victimization which was positively associated with a greater number of HIV risk behaviours. A study conducted by Martin and Kagee (2011) in South Africa, reported that 54% of the respondents met diagnostic criteria for post traumatic stress disorder during their lifetime and 40% of the respondents met criteria for HIV related post traumatic stress disorder. Rizwan and Irshad (n.d) reported that there were mean differences between HIV positive and HIV negative individuals on the scores depression and post traumatic stress disorder. A study conducted by Keuroghlian et al. (2011) found that post traumatic stress disorder symptoms were significantly related to lower odds of adherence in individuals reporting high levels of dissociation but not in those reporting low levels of dissociation. Reif et al. (2011) found that incident stressful experiences frequently occur among individuals living with HIV/AIDS. It was found that 91% reported at least one stressful experience, 61% reported at least one severely stressful experience and 10% reported at least one traumatic event in an average 9 month period. Machtinger et al. (2012) conducted a study among HIV infected persons, found recent trauma had over four times the odds of antiretroviral failure and over three-times the odds of reporting sex with an HIV negative or unknown serostatus partner.

MENTAL HEALTH AND HIV/AIDS:

Mental health problems can strike anybody, but people with HIV are more likely to experience a range of mental health issues. Most common are feelings of acute emotional distress, depression, and anxiety, which can often accompany adverse life-events (American Psychiatric Association, 2012). A study conducted by Bennetts et al. (1999) found that higher level of depression was associated with women who were no longer in the relationship with their partner and who used venting coping strategies.

Overman and Anderson (2001) concluded that anti depressant therapy were effective in most HIV patients with major depression. Another empirical study among HIV infected persons by Nokes and Kendrew (2001) highlighted that sleep quality was significantly associated with symptom severity depressive symptoms, daytime sleepiness, functional status and state anxiety. Johnson et al. (2001) in their article mentioned that low baseline social support predicted increase in hopelessness and depression among HIV infected persons. Based on a study among 162 hospitalized male and female patients with AIDS, Kemppainen (2001) came to the conclusion that the strongest predictor of decreased quality of life scores was depression, with symptoms accounting for 9.75% and female accounting for an additional 8%.

Eller (2001), while investigating the effects of selected variables on quality of life among 81 HIV positive adults noticed that work status, depression and fatigue predicted 50% of variance in quality of life in persons with HIV. Likewise, while examining the role of depression and anxiety disorders between HIV infected women and a comparison group uninfected women, Morrison et al. (2002) concluded that HIV seropositive women without current substance abuse exhibited a significantly high rate of major depressive disorder and more symptoms of depression and anxiety than did a group of HIV seronegative women with similar demographic characteristics. Elliott et al. (2002) evaluated the effects of treatment of major depression on psychological functioning health related quality of life (HRQOL) using quality of enjoyment and satisfaction and social adjustment found that the HIV/AIDS patients with major depressive disorder who completed the clinical trial demonstrated a reduction in depression with response to treatment in HRQOL with exception of work and financial functioning. While investigating the relationship of acute stress reactions among HIV infected men and women to post traumatic stress disorder symptoms to previous traumatic life events with 64 HIV seropositive persons, Koopaman (2002) reported that nearly one-third of the participants' level of acute stress reaction to recent life events that met all symptom criteria for the diagnosis of acute stress disorder. It was found that acute stress reaction to recent life events were significantly and positively to prior-traumatic life events.

Nelson et al. (2002) examined the impact of spirituality and religiosity on depressive symptom severity in a sample of 162 terminally ill-patients with cancer and AIDS and expressed that spiritual well-being was strongly negatively correlated with depression. Religiosity was positively correlated with depression in the multiple regression analysis. Based on a study among persons with HIV infection, Cohen et al. (2002) came to the conclusion that persons who had CD4 count high viral loads were more likely to have higher anxiety or depression, whereas, patients who had CD4 counts higher than 500/mm3 were less likely to be depressed. Cook (2002) reported that high levels of depressive symptoms and poor mental health quality of life were found, and they significantly reduced the probability of

highly active antiretroviral therapy utilization. In a sample of 84 infected patients who were receiving highly active anti retroviral therapy, Safren et al. (2002) found that stressful life events originally accounted for significant portion of the variance associated with depression and perceived quality of life. Morrison et al. (2002), in a study among 93 HIV infected women and a comparison group of 62 uninfected women found that the rate of current major depressive disorder was four times higher in HIV seropositive women than the HIV seronegative women. The HIV seropositive women had higher anxiety symptoms score than the HIV seronegative women. Valente (2003), in their study, found that depressive disorders were common among 20-30 per cent of people living with HIV but the disorders were frequently un-organised.

Ammassari et al. (2004), in their study, among HIV infected persons, noted that strong relationship between adherence behaviour and depressive symptoms, but no significant correlation between adherence behaviour and minor neuro-cognitive impairment. In another study, Kylma (2005) observed that despair and hopelessness were the possible elements in the life situation of person living with HIV and significance others to persons living with HIV. Milan et al. (2005), in their study, among a sample of 76 women living with HIV, noticed that the socio-economic disadvantage and depression were common among the respondents.

Ranucci et al. (2005) revealed that HIV related physical symptoms and optimism were consistently associated with positive affect, negative affect, and depression. Pessimism and coping strategies had a differential association with negative and positive affect, when attempting to understand depression. Stephen et al. (2006) highlighted that social stress and HIV related symptoms were positively correlated with depression and that emotional support was inversely related to depression. Martin and Vosvick (2006) in their study of 205 HIV infected pesons in Dallas, noticed that men who reported higher use of escape fantasy, self isolation, anger and lower use of optimistic planning were significantly associated with depression and women who reported higher level of negative rumination, distancing and anger were significantly related to depression and also there is no significant difference between male and female coping strategies. In a sample of 93 HIV infected persons Martin et al. (2006) revealed that those who used maladaptive coping strategies such as anger and self isolation to deal with the stressors of living with HIV report higher levels of stress and depression.

According to Smith and Vosvick (2006), among 143 HIV positive adults, found that the agency was significantly correlated with quality of life dimensions of perceptions of health, mental health, energy fatigue and cognitive functioning. While evaluating QOL and depression among Senegalese patients receiving efavirenz (EFV) or protease inhibitor (PI) based regimens, Poupard et al. (2007) expressed that 18 per cent of respondents had depression. They concluded that quality of life and depression scores remained good in both study groups. Among 288 HIV+ adults recruited from AIDS service organization, Riggs et al. (2007) found that adult romantic attachment style was significantly related to perceived stress, depression and HIV related stigma, female gender bisexual orientation and greater symptom load were significant predictors of perceived stress levels. HIV related medication was a significant negative predictor and symptom load is a significant positive predictor of depression. In a sample of 226 men living with HIV infection, Uphold et al. (2007) observed that stress was negatively correlated with most of the HRQOL dimensions. In as study among 366 women living with HIV, Wingood et al (2007) found that the HIV discrimination adversely affects mental, sexual and physical health of the women.

While analysing the data collected from 420 HIV positive men and 643 HIV positive women living with HIV/AIDS in Cape Town, South Africa Simbayi et al. (2007) revealed that about 40 per cent of them had experienced discrimination resulting from having HIV infection. A hierarchical regression model included demographic characteristics, health and treatment status, social support, substance use and internationalized stigma significantly predicted cognitive affective depression. In a study among 97 HIV infected person, Kowal et al. (2008) suggested that the targeting depressive symptoms, physical activity and coping strategies as part of comprehensive treatment protocols could help to improve the pain specific to quality of life and overall quality of life among HIV infected persons.

The anxiety for HIV-1 transmission in serodiscordant couples with HIV-1 infected men in Netherlands, Van Leeuwen (2008) noticed that the anxiety level was significantly increased in both men and women. In a sample of 30 heterosexual HIV infected women (mean age 47 years), Ridings et al. (2008) revealed that forgiveness didn't significantly moderate the association between stigma and depression. Hill and Vosvick (2008), in their study among 29 HIV+ adult women observed that respondents with higher forgiveness reported significantly lower level of state anxiety. Forgiveness and loneliness were significantly negatively associated with trait anxiety.

Fincham et al. (2008) perceived that behavioral inhibition was positively correlated with depression, agoraphobia, social phobia and post traumatic stress disorder. Leserman et al. (2008) noticed that alcohol consumption, drug use and symptoms of depression were related to non-adherence in the bi-variate analyses; the effect of these predictors was reduced to non-significance by the stressful event measure. Holzemer et al. (2009) observed higher scores on symptoms, depression and stigma resulted in a lower quality of life. General symptoms and depressive symptoms were significant predictors of quality of life of HIV infection. The findings from a study (Perez et al., 2009) revealed that spiritual striving had direct and indirect inverse effects on changes in depressive symptoms among the adults of HIV. These findings suggest that efforts to enhance women's access to psychological treatment may increase their use of the latest HIV therapies. Sethuramalingam et al. (2010) highlighted that quality of life showed highly significant negative correlations with depression, anxiety and stress. Similarly, quality of life is positively associated with education; income and CD4 count of the HIV infected persons.

CONCLUSION

It is evident from literature and research studies carried out by different social scientists, and medical practioners that the pre and post HIV detection traumas such as sexual abuses, feeling of shyness and shame, lack of support from family, friends and community, social bicot, physical abuse, physical pain, parental neglect, death of a spouse, depression, anxiety, stress, psychiatric disorder, verbal assault, denial of employment, housing or education etc, were found to be common among HIV positive persons. This leads to poor mental health status, like feelings of acute emotional distress, depression, anxiety, lower level of satisfaction with life, elevated levels of loneliness, more maladaptive coping strategy, daytime sleepiness, hopelessness etc, also affected psychological and physical functioning of the HIV/AIDS persons. The physical effects of trauma have been related to significant health problems, such as diminished functioning of the immune system and increased susceptibility to infections. The psychological effects of post traumatic stress disorder manifested in increase risk-taking behavior, such as substance use, poor eating habits, or unsafe sexual activity. In addition, patients with post traumatic stress disorder suffer from depression, social isolation, impairments in trust and attachments, and feelings of anger. Patients with HIV/AIDS are affected by past trauma to the point that it manifests in problems with disease management, such as disrupted or negative interactions with medical personnel and/or medication non-adherence. It also adversely affects the medical interventions. Spirituality and religious based intervention were found to be helpful in coping with the trauma and mental health status of the HIV/AIDS patients. Further probing and studies are needed on interventions aimed at modifying the deleterious effects of depression and trauma among infected with HIV/AIDS. More information and better dissemination of information about what psychosocial and psychiatric treatments might be beneficial for HIV-infected persons presenting with depression, past history of trauma, and post traumatic stress disorder is required. It is critical that clinicians treating HIV infected patients recognize depression and trauma as risk factors for poor health outcomes and thus should screen and treat patients for these problems.

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