

PSYCHOLOGICAL CONSEQUENCES AMONG HIV/AIDS AND HEPATITIS-C PATIENTS

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ABSTRACT

As the Chronic conditions have no cure, the diagnosis of these illness always leaves some negative impact for psychological and social adjustment of the sufferer. In the present study totally 30 women patients suffering from HIV/AIDS were compared with a matched Hepatitis C as well as a matched patient control (suffering from liver failure, liver disease) with respect to different variables like depression, self efficacy, and coping strategies. Beck Depression Inventory (Beck, 1972), Self efficacy (sud, 2002) and Coping Response Inventory (moos, 1996) were administered. The results demonstrated in significant differences on the dimensions of depression, self efficacy, behavioral and avoidance coping of coping strategies.

INTRODUCTION

It is known that stressful events increased by three to five times the risk of developing depression, and that the common triggers of depressive episodes include the following : divorce or separation from a love relationship; serious financial problems; physical disease; problems at home; being laid off; marital problems of problems is an affective relationship; conflicts or difficulties at work; and negative events involving a close person, often find themselves in such situations. HIV positive and Hepatitis C individuals face affective and sexual relationship difficulties; as well as marital conflicts and divorces. The reactions of social exclusion and the physical development of the disease itself result is conflicts at work and even dismissals that can lead to more serious financial problems. All of these stress including factors result in quite frequent depressive episodes, low self efficacy and difficult to Cope up with these diseases (Mello and Malbergier 2006).

AIDS is first and foremost a sexually transmitted disease. Any vaginal, and or oral sex can spread AIDS. AIDS is the end stage of HIV infection. A number of opportunist infections commonly occur at this stage.

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

Psychological Consequences

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 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 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+standardofwomen2005).

HIV positive women face more gynaecological problems as their immune system weakens. These include menstrual irregularities, genital ulcers, STDs like herpes simplex, pelvic inflammatory disease and premature menopause. In addition to the usual opportunistic infections, women are more likely to develop bacterial pneumonia, oesophageal condition (often the first AIDS defining illness), endocarditic, pulmonary TB, kidney failure, bacterial infections and chronic vaginitis. Ongoing studies at Columbia university report that persistent infections of human papillomavirus (HPV) greatly increase the risk of cervical cancer among HIV-positive women (HIV+: standard of care women 2005). The first signs and symptoms of HIV disease progression often lead to a resurgence of more extreme anxiety and depressive symptoms that can often persist indefinitely as patients cope with the uncertainties associated with potential progression to AIDS. Finally, the actual diagnosis of AIDS is often experienced as being very traumatic, because it can signify the “beginning of the end” for patients facing likely death. Severe distress associated with an AIDS diagnosis is often short-lived (Rabkin et al. 1997) suggesting that many people with AIDS show an extraordinary capacity to adopt the advancing disease. Regardless of disease stage, other stressors community experienced by persons living with HIV include the challenge of accessing and paying for medical care, experiences of stigmatization, and bereavement associated with the loss of other loved ones to AIDS (Kalichman & Catz, 2000).

Likewise AIDS hepatitis is also a virus disease. Hepatitis is an inflammation, or swelling of the liver. Alcohol, drugs (including prescription medications), poisons and some viruses can all cause hepatitis. Hepatitis C is a liver disease caused by the hepatitis C virus (HCV). (www/httppageHepatitisC.htm 2005).

Hepatitis C virus (HCV) is also known to be responsible for a substantial number of cases of acute hepatitis. It usually produces a mild attack of symptoms or even none at all, but around half of these infected go on to develop chronic hepatitis. In some of these (20%), the illness is the serious form of chronic acute hepatitis and HCV is also implicated in cirrhosis and hepatocellular carcinoma (liver cancer). A number of people become carriers of HCV without showing any symptoms of illness. It is believed that a proportion of these may eventually develop some form of liver disease. (Gedders & Grosset 2000).

HCV is transmitted through infected blood in the following ways : sharing infection needles or works, sharing needles that are used to apply tattoos, receiving a transfusion of blood, blood products, or organs, mother to baby transmission (in pregnancy), unprotected sex (uncommon) ([www/http://:page hepatitis-2005](http://page hepatitis-2005))

Hepatitis C (HCV) affects women differently than men, women, especially if they were young at the time of acquiring the virus, are less likely than men to progress from acute to chronic HCV. Women, especially premenopausal women, appear to progress to cirrhosis less often than men (Palmer, M.D. 2004).

Many people who are infected with HIV don't even know it because they have no symptoms. Early signs of HCV can seem like the flu and often go unnoticed.

Signs of HCV include : Jaundice yellowing of the skin, eyes, and mucous membrane, dark colour urine; stool that appears pale and clay like, fatigue; loss of appetite, nausea; diarrhoea; fever and chills; vomiting; pain in the liver area ([www.http//page hepatitis C 2005](http://page hepatitis C 2005)).

Women experience side effects more frequently than men, women more frequently suffer from fatigue, headache, depression, anxiety, irritability and insomnia, cosmetic concerns, sexual problems, menstrual irregularities, and bone loss problems that women with HCV may encounter while on antiviral therapy.

Co-infection can complicate treatment, people with liver damage due to chronic hepatitis are more likely to experience hepatotoxicity (liver toxicity) related to anti HIV drug. In addition, drugs used to treat HIV and hepatitis can interact and side effects may be exacerbated. Confection refers to infections with two or more different disease causing organisms. Hepatitis C is a common coinfection in people with HIV. An estimated 200,000-3, 00,000 people in the U.S. have both HIV and HCV. Experts believe that about 25% of Americans with HIV also have HCV.

Psychological Consequences

Experts believe that about 25% of Americans with HIV also have HCV. HIV/AIDS/HCV confection is increasingly recognised as a growing public health problem. (www.body:SFAFBETA-HIV and Hepatitis co infection 2005).

The patients of HIV / AIDS and hepatitis C often face the depression, low self efficacy and poor coping strategy. Depression ranks as one of the major health problems of today. Million of people suffering from some form of this disorder crowd the psychiatric and general hospitals, the outpatient clinics, and the offices of private practitioners. Depression may appear as a primary disorder or it may accompany a wide variety of other psychiatric or medical disorders. Not only is depression a prominent suicide, is a leading cause of human death in certain age groups. Depression is treated as a clinical entity that has characteristics occurring in time; in terms of onset recovery and recurrence.

Clinical depression as distinct from normal dejection is a serious psychological disturbance with no redeeming characteristics. The psychological pain experienced in severe and long lasting and may intensity with passage of time. It is no debilitating that clinically depressed person may reach a point where they are unable to carry out the simplest of life's activities. (Comer, 1992).

Depression is also an under diagnosed disorders in the general population. Symptoms evident at the time of a cancer diagnosis may represent pre-existing condition and warrant separate evaluation and treatment. Clinical depression is a psychiatric disorder characterized by an inability to concentrate, insomnia, loss of appetite, absence of pleasure, feelings of extreme sadness, guilt, helplessness and hopelessness and thoughts of death (Julia & Rowland, 1999).

Self efficacy refers to beliefs about one's capabilities to learn or problem behaviour at designated levels. Efficacy beliefs influence how people feel, think, behave and motivate themselves. It is defined as individuals conviction about his/her abilities to mobilize cognitive, motivational and behavioural faculties needed to successfully execute a specific task within a given context (Stajkovic & Luthans, 1998). Self efficacy beliefs influence the choices people make and the course of action they pursue. Individuals tend to engage in tasks about which they feel competent and confident and avoid those in which they do not.

Perceived self-efficacy represents the belief that one can change risky health behaviours by personal actions, e.g. by employing one's skills to resists temptation, behaviour change in seem as dependent on ones perceived capability to cope with

stress and boredom and to mobilize one's resources and causes of action required to meet the situational demands. Perceived self efficacy has become a widely applied theoretical construct in models of addiction and relapse. (Donovan & Marlatt 1988; marlatt, Bear & Quigley, 1994; Marlatt & Gordon, 1985). This view suggests that success in coping with high risk situations depends partly on people's beliefs that they operate as active agents of their own actions and that they possess the necessary skills to reinstate control should a slip occur.

Lazarus (1996) defined “coping mechanisms” as strategies used by the individual to deal with threat. According to Lazarus and Folkman (1984) “coping is the process of managing demands (external or internal) that are appraised as taxing or exceeding the resource of the person”. He further describes that coping consists of efforts, both action oriented and intrapsychic, to manage (i.e. master, tolerate, reduce, minimize) environmental and interval demands.

Coping is seen as a cognitive activity that involves the appraisal of threatening conditions and the consequences of the coping behaviour (Lazarus & Folkman, 1984).

Coping refers to cognitive and behavioural responses to disruptive and otherwise stressful life events that tax the persons' capacity to adjust (Pearlin & Schooler, 1978; Folkman & Lazarus, 1980).

Coping is influenced not only by the internal resources an individual has but also by external resources like time, money, education living standard and social support. External resources may have little effect on a person's coping success at low levels of stress, but may become important a high level of stress. In examining the buffer hypothesis studies reveal that personal resources like health, self esteem, social support, education and living status do not reduce the likelihood of experiencing a stressful event. They only mute the impact of such events and protect the individual against depression. (Khokhar, 2003).

The present research was aimed at studying the effect of depression, self efficacy and coping strategies among AIDS and hepatitis C women patients.

Hypotheses

On the basis of review of literature the following hypotheses were formulated.

1. There will be significant difference in the level of depression between the women patients of AIDS and hepatitis C.
2. There will be significant difference in the self efficacy between the women patients of AIDS and Hepatitis C.
3. There will be significant difference in the coping strategies of women patients of AIDS and Hepatitis C.

METHOD

Sample :

60 women patients were taken for the study, out of which 30 were patients of AIDS and 30 were of Hepatitis C, age between 31-50 years.

Tools :

1. Beck Depression Inventory (BDI) (1961) by Beck was used to measure depression. This inventory is a multiple choice self report measure of cognitive, affective, behavioral and somatic aspects of depression.
2. Self Efficacy Scale by Sud (2002) was used to measure the self efficacy of the women patients. This scale consisted of 10 items. Each item has a four choice responses pattern ranging from "Not at all true" which scores '1' to "exactly true" which scores '4'.
3. Coping Response inventory (CRI) by Moos (1996) was used to measure the coping response in various categories such as cognitive, behavioral, approach and avoidance coping.

PROCEDURE

The HIV/AIDS and Hepatitis C women patients were contacted at the OPD and gastroenterology ward of SMS Hospital Jaipur. The patients were given the scales and their responses were collected. If there were some probing was needed it was done.

RESULTS AND DISCUSSION

The data obtained on the basis of administration of tools were analysed with the help of different statistical techniques like mean, SD, 't' etc. and the results are presented in the tables to follow.

Table 1 : Mean, SD and t value for the scores of depression of AIDS (N=30) and Hepatitis C women patients (N=30)

Group	Mean	SD	t-value
AIDS	35.93	8.46	-7.064**
Hepatitis C	17.27	8.95	

*** P<0.001

Table 2 : Mean, SD and t value for the scores of self efficacy of AIDS & Hepatitis C Women Patients

Group	Mean	SD	t-value
AIDS	20.60	7.17	2.920**
Hepatitis C	25.53	5.85	

** P<0.01

Psychological Consequences

Table 3 : Mean, SD and t values for the scores of coping Responses of AIDS and Hepatitis C women patients

Group	Mean	SD	Mean	t-value
Cognitive Coping	AIDS	31.73	6.66	9.49
	Hepatitis C	33.20	5.22	
Behavioral Coping	AIDS	28.80	6.06	3.244**
	Hepatitis C	33.07	3.89	
Approach Coping	AIDS	29.57	9.83	0.351
	Hepatitis C	30.27	4.73	
Avoidance Coping	AIDS	30.97	4.39	4.601***
	Hepatitis C	36.00	4.08	

** P<0.01

*** P<0.001

The result (table 1) indicate that there were significant differences in the level of depression among the women patients of AIDS and Hepatitis C as mean scores on depression were found to be 35.93 and 17.27 for the patients of AIDS and Hepatitis C respectively. The level of depression was found much higher among the AIDS patients as evident from the results. The mean scores on depression for the said group was found 35.93 against the maximum possible scores of 24 considered severe depression whereas for the Hepatitis C patients it was 17.27 which was considered in the category of moderate depression. The difference between the scores of two groups, was also found to be significant ($t = -7.064^{***}$). On the basis of the result, it can be said that HIV/AIDS patients have greater level of depression because

of mood disorders, pessimism, sense of failure, lack of satisfaction, guilt feeling, sense of punishment, self hate, fatigability, loss of appetite etc. Similar findings was also obtained by 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.

Thus it can be inferred that AIDS patients suffer from severe depression unlike the Hepatitis C patients. Hence the hypothesis of significant difference between the two groups of patients with regard to their level of depression is found to be confirmed.

Table 2 indicates that there were significant differences between the scores of self efficacy of AIDS and Hepatitis C women patients as the mean scores for the two groups of patients were found to be 20.60 and 25.53 respectively. The findings clearly indicated that the self efficacy of hepatitis C patients were certainly better than the patients of AIDS. The 't' value between the scores of two groups was also found to be significant ($t=2.920^{**}$) which indicates that patients of Hepatitis C learn to actively self manage their chronic hepatitis C virus (HCV) infection and ultimately, to improve health outcomes for veterans with HCV (Clinical Trails Court 2008).

Similar findings was also obtained by McKay (2001) hypothesized that continuing care participation would increase self efficacy, social support, treatment motivation and self help participation and would reduce the risk for relapse to substance use while suffering from liver disease such as hepatitis C.

Thus it can be said that hepatitis C patients receive more social support from family and friends to build up and raise the self efficacy than the AIDS patients. That is why patients of hepatitis C differ from patients of AIDS on self efficacy which supports the hypothesis 2.

Table 3 shows that there were significant differences between the scores of coping responses among the AIDS and Hepatitis C patients. Mean scores on Behavioral coping were found to be 28.80 and 33.07 for the patients of AIDS and Hepatitis C respectively. The results clearly indicated that the hepatitis C patients use more behavioral coping than the AIDS patients. The difference between the scores

Psychological Consequences

of two groups was also found to be significant ($t=3.244^{**}$). On the basis of results, it can be said that hepatitis C patients do more behavioral attempts to seek information, guidance or support and take action to deal directly with the problem.

There were also significant differences between the scores of avoidance coping of AIDS and Hepatitis C women patients as mean scores on avoidance coping were found to be 30.97 and 36.00 for the patients of AIDS and hepatitis C respectively. Result showed that the hepatitis C patients were certainly more used the avoidance coping rather than the AIDS patients. The 't' value between the scores of two groups was also found to be significant ($t=4.601^{***}$) which indicates that patients of hepatitis C do more cognitive and behavioral attempts to avoid thinking about their stressor and its implications. Avoidance coping tends to be emotion focused. Patients of hepatitis C do more behavioral attempts to get involved in substitute activities and create new sources of satisfaction and to reduce tension by expressing negative feelings.

Similar findings was also obtained by Constant et al (2005) described the "monitoring and blunting" hypothesis. These hypothesis posit that people can adopt two different cognitive attitudes towards relevant information to cope with a stressful situation in chronic hepatitis C.

Coaghlán et al (2004) found most women post treatment felt more positive and informed about their illness, had more confidence and reported a greater ability to control and cope with their lives. Cognitive behavioral therapy (CBT) emphasized the important role of thinking. It helps to alleviate emotional distress and to address a myriad of psychosocial behavioral issues. The approach is effective in life threatening disease such as Cancer, AIDS & liver problem. Thus it can be said that effectiveness of (RSM psychology Centre 2006) coping strategies depends the nature and type of stress that is why patients of hepatitis of hepatitis C differ significantly from patients of AIDS on coping responses of behavioral coping and approach coping which supports of hypothesis 3.

CONCLUSION

Today a fundamental issue and concern for the society is how to help the women patients of AIDS to reduce their depression level built up their self efficacy and positive or fighting coping strategy, their self worth and identity their individuality their ability to self actualize so that they may have good mental health and do not suffer from depression, lower level of self efficacy and poor and negative coping strategies. In India people do not accept easily a woman who is suffering from HIV/AIDS. People even their family members and friends start to isolate from the

infected women. Thus the women often experience a mixture of shock, denial, guilt and fear as well as concerns about whether to disclose the illness to others. These women frequently experience a profound sense of disappointment often blaming themselves. It can be concluded that the AIDS patients need more family and social support to reduce their depression as well as to improve their self efficacy and coping strategies.

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