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Psychological Stress on Aids Patients of Situation

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Abstract: *The HIV/AIDS infected patients can live healthy lives for longer if proper care and support is provided. Their immune system can be strengthened by medical treatment, healthy food, regular exercise and peaceful rest. Emotional support and a positive attitude will help the PLWHAS to avoid mental disorders. The impact is disproportionately high on those who are socially, sexually economically and psychotically vulnerable. The vulnerability is mostly in low socio economic families. The families and sometimes infected individuals are forced to cope with HIV/AIDS without getting community support. An individual who is HIV positive and he or she become ill, the entire families and children bear the burden alone. Loneliness, anxiety, stress, mental confusion, depression, if any one of their parents are infected by HIV/AIDS. Due to disclosure fears and stigma associated with HIV/AIDS many families isolate themselves from their extended family and communities to save themselves and their children from maltreatment. PLWHAS needs a lot of emotional, spiritual, psychological, social, physical, clinical and nursing care, ART drugs to ensure their quality of life. However with increased long life posed numerous challenges to mental health professionals for providing services to conditions which are arising at different stage of disease progressing from HIV to AIDS. The progression rates to AIDS, Psychological disturbances and clinical manifestations of diseases associated with HIV infection might differ across different stages of HIV to AIDS disease progression. Previous investigations found different rates of HIV disease progression and associated psychological symptoms varied among asymptomatic, symptomatic and AIDS indicator conditions.*

Key Words: *Psychological Stress, AIDS Patients, Mental Health.*

1. INTRODUCTION :

HIV/AIDS is a disaster, which disrupts the family's‟ equilibrium by placing a dark and frightening cloud over their future. It is one of the most challenging public health problems of our country. The HIV/AIDS infected patients can live healthy lives for longer if proper care and support is provided. Their immune system can be strengthened by medical treatment, healthy food, regular exercise, rest, care and support. The psychological and social squealers of HIV/AIDS infection is divesting to families who are affected. They need a compassionate multifaceted assistance and support which will enable them to find meaning in life, appraising their survival, taping new sources of psychic strength and courage.

Globally there are 33.3million people living with HIV and in SEAR (South East Asia Region) about 3.5 million people. India also has the world's third-highest total HIV burden; the prevalence of HIV infection is estimated to be 0.34% of the population, which translates to 2.31 million people living with HIV/AIDS (PLHIV) and Tamil Nadu is among high prevalent states There are an estimated 4.2 million people living with HIV in Asia, 90% of them are in India, China and Thailand. India contributes 49% of it (2.4 million people). The first few cases of HIV in India were detected in 1986 among sex workers in Chennai and the first AIDS case was reported in 1987 in Mumbai. In India, HIV was going along with stigma, discrimination, depression, suicidal tendencies and violence. Right from the beginning of the epidemic, an AIDS task force was established by the Indian Council of Medical Research (ICMR) for screening risk behavior of such groups.

1.1 BIDIRECTIONAL LINK OF HIV AND MENTAL ILLNESS

The relation between HIV and mental illness has been studied by examining HIV infection in those with mental illness and mental illness in those with HIV. However, there are many common factors in both, such as homelessness, incarceration, and poverty and substance misuse. There is some evidence to suggest that HIV risk in people with severe mental illness is mediated through substance misuse. In addition to this avenue of investigation, there has been exploration of the impact of psychological morbidity on disease progression, response to treatment and outcome of treatment.

1.2 PSYCHOSIS

Psychotic symptoms seen in HIV-infected individuals may be primary or secondary. Occasionally psychotic symptoms may be the presenting complaints of an HIV illness. One case report highlights the presentation of progressive multifocal leukoencephalopathy (PML) being camouflaged by catatonic symptoms, thereby emphasizing the need for detailed investigations in such a presentation. Primary psychosis does not yield any signs of HIV cerebral disease whereas secondary psychosis often occurs in the context of global (encephalopathy) or localized pathology (most often lesions of the left temporal lobe and diencephalon). Other factors that need to be considered in the differential diagnosis include presence of opportunistic infections like tuberculoma, toxoplasmosis and cryptococcal meningitis, which may present as acute psychosis in the initial stages.

HIV/AIDS disease affects all dimensions of an individual's quality of life such as physical, psychological, social and spiritual. Counseling and family/social support to be able to help people and their careers cope more successfully with each period of the infection and improves quality of life. This support helps PLWHAS are less likely to develop serious mental health problems. HIV Infection often results in loss of socio-economic status, employment, income, housing, health care and mobility, for both individuals who are infected by HIV and their partners and families. Psychosocial support helps to assist people in making informed decision, coping better with illness and dealing more effectively with discrimination. It improves the quality of their lives of HIV infected individuals and prevents further transmission of HIV infection in latter stage. The psychosocial support is also equal importance for people with HIV/AIDS who must adhere ART or T.B treatment, regular on-going counseling in enhancing adherence to treatment regimens.

1.3 DEPRESSION

Emotional problems are among the most common symptoms in HIV patients with up to 98.6% prevalence. Depression is a prevalent comorbidity in HIV infection as well as a recognized side-effect of NRTI, Protease inhibitors and NNRTIs. It may also be the first presenting symptom in an HIV case. It is essential to discriminate between normal response to a life threatening illness, clinical manifestation of HIV and depressive episode while recognizing that all three can coexist. As in other serious medical illness, anhedonia may be the most reliable indicator of severe depression. HIV infected individuals are recognized to be at high risk of suicide in the period immediately after coming to know of seropositive status, especially if they have a past psychiatric history. Chronic pain, commonly encountered in HIV, both due to disease as well as treatment related side-effects, is often associated with depression.

1.4 SUICIDE

HIV can be a significant risk factor for suicide. Chronic pain, anxiety and depression should prompt a thorough suicidal risk assessment. Suicidal attempt is most likely to occur in those with a history of psychiatric illness and in the immediate aftermath of diagnosis with HIV.

1.5 ACCEPTANCE

The Newly diagnosed HIV/AIDS infected patients may be in a state of shock, disbelief, and be very anxious. They may not be easily accepted this disease which is not a curable one. This leads them to disrupt the patient's usual coping strategies. The patients may also feel guilty about the sadness the illness will cause loved one and families and children. They are easily denial the social responsibilities that go along with being HIV infection.

2. OBJECTIVES OF THE STUDY:

- To understand the level of Psychological stress among mental health asymptomatic acute HIV group, symptomatic condition group and AIDS Patients.
- To know the depressive symptoms among asymptomatic acute HIV patients, psychological stress of clinically symptomatic condition group and AIDS patients.

3. DISCLOSURE:

This is a very difficult area for all infected by HIV/AIDS. They are always needs helps from others in the welfare organization to handling this issue, because the HIV infected individual members needs time to first deal with their own emotions before they tell other people. Due to disclosure fears and stigma associated with HIV/AIDS, many families isolate themselves from their traditional families and communities to save themselves and their children from maltreatment, rejection and prejudice. Thus they are cutoff from the valuable support.

3.1 MENTAL HEALTH ISSUES AMONG MSM WITH HIV INFECTION

Men who have sex with men are at high risk for HIV and this group has been poorly studied in India compared to the Western world. This group includes Kothis (receptive, feminine), Panthis (penetrative, masculinized) and Hijras (transgender, hermaphrodite, castrated). The Kothis and Hijras are more likely to bear the brunt of social stigma with HIV as they are bracketed with female commercial sex workers and have less support coming their way. It is crucial that psychiatrists sensitively inquire regarding sexual preferences even when the patient is in a heterosexual relationship.

3.2 SOCIAL AND ECONOMIC

The main social and economic impacts for people living with HIV are loss of labour or education due to illness and increased expense of healthcare and transport. The compounding of these impacts often leads to increased levels of poverty, food insecurity and nutrition problems.The HIV –specific intervention are aimed at organization, government in an effective way, to alleviate economic problems (support for funerals and burial societies). When people are stabilized on ART and well enough to work, a more long–term plan of attack can be effective through livelihoods interventions such as income generation, access to loans/banks and land, skills training and employment opportunities programmes. In workplace, policies and programmes can ensure appropriate socio-economic support mechanisms for HIV positive staff as well as confront stigma and discrimination. Capacity building and advocacy support can be provided to networks and groups of people surviving with HIV to build their ability to bid for their rights to the comprehensive scope of care and funding services. Non-HIV Interventions are interventions aimed at the general public, by adopting efficient means (social protection) of ensuring both people infected and affected by HIV benefit.

3.3 THE LEVEL OF PSYCHOLOGICAL STRESS INCREASED ACROSS STAGES OF HIV TO AIDS

People in symptomatic acute HIV and AIDS conditions exhibit a greater amount of psychological stress compared to people in asymptomatic acute HIV condition. But there is no difference between Symptomatic acute HIV and AIDS conditions on the level of Psychological stress. People who are in symptomatic acute HIV and AIDS conditions didn't show the significant difference in the amount of Psychological stress. This clearly indicates that HIV to AIDS disease progression increases the level of psychological stress up to one level when people started to cope up and adopted with the condition they may not show the increased amount of Psychological stress. Hence, there may not be a considerable difference between symptomatic acute HIV and AIDS conditions.

Since illicit substances, other techniques are often used to help people self medicate psychological stress, depression, and death anxiety in HIV population, an attempt to exclude participants who reported a history of drug use and special techniques was made to help control for this possible confound. Although the prevalence of drug use and other techniques were asked in this study, other substance abuses and self-medicating issues were not been controlled. In future it’s other techniques such as yoga, meditation, counseling and their impact on the experience of psychological stress, depression, and death anxiety, in the HIV population.

3.4 PSYCHOLOGICAL ISSUES THROUGH DISEASE PROGRESSION OF HIV/AIDS

Among health care professionals who work with people living with HIV/AIDS, the question of how psychological experiences affect the progression of HIV to AIDS is likely to arise. Due to the bidirectional relationship of the communications of the mind and the body's immune system, this is a problematical scenario. The reality is that HIV adversely interferes the function of the immune system during the course of its progression to AIDS creates greater confounds to understand these interrelated system. At the initial stage of the infection people see themselves that they are victimized by the HIV—outer, unknown, evil object. As the disease progresses from HIV to AIDS psychological and biological stress, anxieties, death thoughts, fear are common in these people. As the epidemic progressed from HIV to AIDS, people experience increased loss of control on their body so the power (or control) issues arose. Active engagement in their health maintenance and self efficacy can increase their awareness of having control and reduce their risk of experiencing the sense of helplessness. But their belief may change with desolation.

3.5 PSYCHOLOGICAL STRESS

Stress is all about perception, the state of a person. Wide range of individual differences exists in experiencing stress. A stressor to one person same would not be the stressor to another person and different to others. HIV infected people have more chances of experiencing stress than general population. HIV-infected people are more prone to face several stressors in day to day’s life, which adversely affect their health condition. In understanding the correlation between stress and HIV-infection, there is no direct association between stress and HIV disease course. Earlier studies have found that stress reduces the function if immune system one’s body so that immune system fails to defended against various

infections, the stress impact do not stop there. The physiology supports for the mechanism that when people are stressed, the nervous system gets activated so they are more sensitive to pain, to emotional stimuli, and more easily stressed.

Disease progression itself could be a source of the psychological problem and other symptoms. Although medically symptomatic HIV+ patients often report higher rates of depression compared with asymptomatic HIV+ or HIV– comparison groups, as noted it requires effort to distinguish between somatic symptoms of depression, such as weight loss and fatigue, and concurrent medical symptoms.

4. CONCLUSION :

It is very difficult to assess the accuracy levels of psycho-social problems and its impact among the HIV/AIDS patients. A number of small scale studies have shown that the relationship between increased access to HIV/AIDS treatment and a reduction in psycho-social issues especially social stigma and discrimination is not always clear. In this aspect the Government must motivate the NGOs and CBOs personnel to involve various types of community participation programme until the community gets fully sensitized and accept the HIV infected people as one of the members in the community. In this regard, a sincere, dedicated social workers role is very important to bring dreams of the Government plans and strategies true. Therefore the research study thus concludes the active participation of the community alone alimiroate the evil cause of HIV/AIDS. The impact of illness on the life of the individual, the association of substance use and HIV, and the relationship of treatment and mental health need to be addressed. HIV challenges the psychiatrist to consider systematic and diverse methods in assessment, consider several possibilities in the differential diagnosis and also be aware of the problems related to use of different medications. In developing countries like India, specific issues such as comorbid infections, IV drug use and stigma and inadequate facilities for HAART and palliative care add to the mental health burden.

REFERENCES:

1. Ankrah,M. The impact of HIV/AIDS on the Family and other significant relationships: the African Clan revisited. AIDS care, 1993, 5:5-22.
2. Chandra PS, Krishna VA, Ravi V, Desai A, Puttaram S. HIV related admissions in a psychiatric hospital: A five year profile. Indian J Psychiatry 1999;41:320-4
3. Dowsett G. HIV/AIDS and homophobia: Subtle hatreds, severe consequences and the question of origins. Culture Health Sexuality 2003;5:121-36.
4. Israelski, D. M., Prentiss, D. E., Lubega, S., Balmas, G., Garcia, P., Muhammad, Koopman, C. (2007). Psychiatric co-morbidity in vulnerable populations receiving primary care for HIV/AIDS. AIDS care, 19(2), 220-225. Retrieved from http://www.tandfonline.com/toc/caic20/current.
5. Nath L.M. (1998), The epidemic in India: an overview, in Godwin P. (Ed),The looming epidemic: The impact of HIV/AIDS in India", Mosaic books/New Delhi., p.28.
6. Park k. and Park J.E Text books of Preventive and Social Medicine, Jabalpur, Banarsids Bhanot's Publishers 2005.
7. Pandya A. Voices of Invisibles: Coping responses of Men who Have Sex with Men (MSM). Strength Based Strategies International Conference Towards Strength Based Strategies that Work with Individuals, Groups and Communities. 2006. p. 10-2. November. Hyderabad, India.
8. Rao VR, Sas AR, Eugenin EA, Siddappa NB, Bimonte-Nelson H, Berman JW, et al. HIV-1 clade-specific differences in the induction of neuropathogenesis. J Neurosci 2008;28:10010-6
9. Ross, M. W., Tebble, W. E., & Viliunas, D. (1989). Staging of psychological reactions to HIV infection in asymptomatic homosexual men. Journal of Psychology, & Human Sexuality, 2(1), 93-104. Retrieved from http://www.tandfonline.com/toc/wzph20/current.
10. UNAIDS. Caring for carers: managing stress in those who are care for people with HIV/AIDS. Best Practice Collection UNAIDS/00.08E, 2000.
11. UNAIDS (2008) „India: Country Situation.
12. UNAIDS (2010), UNAIDS report on the global AIDS epidemic.