Psychological Problems among Patients Suffer in HIV/AIDS in Pakistan

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1. Introduction

It is reported that more than 34 million HIV infected people exist around the world (UNAIDS, 2015). Since the past 30 years, a total of 4882450 people from Pakistan have been screened for HIV. The overall prevalence rate was estimated at 0.041% (95% CI: 0.0-6.79). Maximum infection rate 15.05% (SE=4.27%) were observed among injecting drug users, followed by refugees 2.63%, sex Workers 2.63% and Prisoners 1.32% (Ali et al., 2017). According to UNAIDS estimates, about 130,000 people are living with HIV in Pakistan. Many factors, including low literacy rates, high levels of poverty and risky blood transfusions, have made Pakistan more at risk to HIV infection than other countries (UNAIDS, 2016). Stopping the spread of HIV and caring for those infected is one of the major health and humanitarian problems. HIV management highlights four key areas: (1) early diagnosis; (2) timely use of medication for treatment, (3) full adherence to treatment programs and (4) commitment to risk reduction practices (UNAIDS, 2015). Among four factors, treatment adherence is one of the important factors in preventing the emergence of viral failure and drug-resistant viruses (Marks et al., 2010). However, adherence and retention of treatment remain a long-
Patients of antiretroviral therapy (ART) adherence can be affected by many factors such as the degree to which experience stigmatization (Okoror et al., 2013; Kingori et al., 2013; Peltzer and Ramlagan, 2011), the extent to disclose the status (Qiao et al., 2012; Nokuthula, 2006) and how HIV-positive patients cope (Makoae et al., 2008). Also, various forms of stigma are a crucial factor which affects the ART adherence (Kingori et al., 2013). The stigma can take many forms such as avoidance, exclusion, denial violence, isolation, of service, awkward social interactions, physical distance and accusations, and have harmful effects on the social, mental and physical health for patient with HIV (Stutterheim et al., 2009; Mak et al., 2007). Self-stigma can lead to inferiority and anger. Enacted perceived or public stigma can cause the social and psychological response of others to stigmatized people (David et al., 2007). People with HIV-negative and partnered living with HIV person (in a serodiscordant relationship) may suffer from a form of indirect stigma (witnessing or hearing stigma about HIV-related which then becomes internalized) (Koesteret al., 2017).

More importantly, the HIV-related stigma is affected by the disclosure of HIV status. Previous studies have shown that perceived stigma and disclosure negatively correlated (Smith et al., 2008) because of the disclosure can lead to stigmatization (Stutterheim et al., 2009; Black and Miles, 2002). The literature on disclosure suggests that when disclosure does occur, it does not happen in a systematic way (Odiachi A 2107). In contrast, study shows that information of disclosure can be an essential means of reducing the stigma associated with HIV (Brown et al., 2003). Disclosure may have beneficial consequences for people living with HIV, including greater mental health (Stutterheim et al., 2012; Kalichman et al., 2003; Smart and Wegner, 1999), good in relationship (Toth et al., 2013; Smith et al., 2008), social support (Toth et al., 2013) and improve treatment and safe sex (Stirrratt et al., 2006).

A study showed that stigma and disclosure are also relevant to the coping (Qiao et al., 2012). Stigma can pose a major obstacle to a person's acceptance of HIV (Ncama et al., 2008) and disclosure is also part of the coping method (Holt et al., 1998). Positive reappraisal induces better-coping outcomes (Moskowitz et al., 2009). Treatment adherence in patients of HIV was identified as having a positive effect on coping (Silva et al., 2018), and religious coping can be used as a psychological resource to cope with adversity. Treatment adherence of patients could indicate their treatment motivation. A high degree of stigma is associated with poor treatment adherence (Nam et al., 2008).

The non-disclosure has limited opportunities to improve ART treatment, and disclosure has found more improvement in ART treatment (Fair and Albright, 2012). However, the relationship between treatment motivation, coping style, stigma and self-disclosure among people living with HIV/AIDS in Pakistan had not thoroughly studied.

The present study aims to compare the gender and marriage state differences in treatment motivation, coping style, stigma, and self-disclosure of HIV/AIDS among HIV patients and explore the relationship among treatment motivation, stigma and disclosure among HIV patients in Pakistan.

2. Methodology

The researcher used the convenient sampling technique for gathering the data. The researcher selected 287 HIV/AIDS patients including 65 female and 222 male from six districts (government hospitals) of were included in the study. Data collected from the (voluntary,
confidential counseling and testing center) hospitals. An (information session) delivered regarding the nature and treatment adherence of HIV/AIDS, and informed consent was taken and make sure the privacy and confidentiality were maintained. Moreover, face to face interview was conducted to collect the data from participants and instructed them to choose only one appropriate option regarding their actual symptom or feeling. According to standard procedure, scoring was performed from gathered data and proceeds for statistical analysis to compute results and formulated tables.

3. Measurements

The four validated scales were used to assess treatment motivation, stigma and self-disclosure of HIV patients.

3.1 Treatment Motivation Questionnaire (TMQ)

TMQ (Ryan, Plant & O'Malley, 1995) consists of 26 questions, which divided into four subscales, the 7-point Likert level (1 = not at all; 7 = very true) used. The first sub-scale "External Reasons" includes projects that reflect the apparent lack of choice of the subject in seeking treatment, as well as the experience of maintaining external pressure for treatment (For example, if I don't continue to receive treatment, I will be in trouble). The second sub-scale "Internal Reasons" includes items that reflect the excitation dynamics that have identified and inserted. (For example, I came to the clinic for treatment because it was important for me to solve my problems). The third sub-scale of "confidence" includes items that reflect the subject's expectations for positive treatment outcomes. (For example, I believe this program will work for me). In the fourth, "Help-Seeking" Measures the motivation to share problems and connect with others. (For example, I want to go public with other people in the program). It is study found that Cronbach's alpha value levels ranging from .72 to .96.

3.2 Stigma Scale

Stigma Scale developed by (King et al., 2007). Each of the 28 questions gets a greater stigma by 0-4. In the direction of agreement questions marked with an A are scored 0-4, while that in the direction of disagreement marked D scored 0-4. Cronbach’s a for responses to the final version of 28 items was 0.85. No single item deletion improves internal reliability by more than 0.88. The first sub-scale Cronbach’s a (discrimination) was 0.86; second (disclosure) 0.84 and third (positive aspects) 0.74.

3.3 Emotional Self Disclosure Scale (ESDS)

The ESDS (Snell et al., 1988) was administered to participants to assess their willingness to disclose their emotions to family or friends. This scale has 40 items. The ESDS has eight subscales, every subscale containing five items. The subscales based on Exposure to feelings related to depression, happiness, jealousy, anxiety, anger, calm, apathy, and fear. The item responses ranked according to the five-point Likert type ratio, from 1, not willing to discuss at all, 5, fully prepared to discuss. The project summary forms a comprehensive score. Cronbach's alpha and test-retest internal reliability consistency measured range from low 0.82 to high 0.94.
4. Results

4.1 Demographic characteristic of the subjects

Of the 287 HIV-infected individuals 222 were men and 65 women. Frequency and percentage are given for demographic variable in the table 1.

Table 1 Frequency distribution of demographic variables

| Variables     | Category   | Frequency (%) |
|---------------|------------|---------------|
| Gender        | Male       | 222(77.4)     |
|               | Female     | 65(22.6)      |
| Age           | < 25       | 160(55.7)     |
|               | 25-45      | 117(40.8)     |
|               | > 45 Years | 10(3.5)       |
| MS            | Single     | 90(31.4)      |
|               | Married    | 197(68.6)     |
| Education     | Primary    | 240(83.6)     |
|               | Secondary  | 30(10.5)      |
|               | High       | 17(5.9)       |
| Profession    | Employed   | 260(90.6)     |
|               | Unemployed | 27(9.4)       |
| Income        | < 15000    | 173(60.3)     |
|               | 15000-30000| 68(23.7)      |
|               | < 30000    | 46(16.0)      |
| Living With   | Divorced/widow | 40(13.9) |
|               | Nuclear    | 80(27.9)      |
|               | Joint      | 167(58.2)     |
| Diagnoses     | < 1 Year   | 60(20.9)      |
|               | 1-4 Years  | 150(52.3)     |
|               | < 4 Years  | 77(26.8)      |

4.2 The Correlation between Treatment Motivation, Stigma, and Self-Disclosure

As shown in table 2, treatment motivation significantly positively correlated with self-disclosure while insignificantly correlated with HIV stigma. Similarly, HIV stigma significantly positively correlated with disclosure.

Table 2 Correlation between treatment motivation, stigma, and self-disclosure

| Variables           | TM   | SS  | DS  |
|---------------------|------|-----|-----|
| Treatment Motivation| 1    |     |     |
| Stigma              | 0.117*| 1   |     |
| Self-Disclosure     | 0.341**| 0.279**| 1   |

Note: ** Correlation is significant at the 0.01 level (2-tailed)
4.3 Multiple linear regression analysis
As shown in table 3, stigma, self-disclose and coping style significantly positively predicted the treatment motivation. Furthermore, we can conclude that one unit change in stigma will 0.251 changes in treatment motivation, also self-disclose change 0.362.

Table 3: Multiple Linear Regression Analysis

| Dependent Variables | Independent Variables | Un-standardized Coefficients | SE  | t    | F   | $R^2$ |
|---------------------|-----------------------|------------------------------|-----|------|-----|-------|
| Treatment motivation| Constant              | -12.82                       | 1.3 | 9.86 *** | 49.05 | 0.324 |
|                     | Stigma                | 0.251                        | 0.10| 2.51 ** |       |       |
|                     | Self-disclose         | 0.362                        | 0.07| 5.17 ***|       |       |

*Note:* *** sig. ≤0.001 and ** sig. ≤0.01

4.4 The Gender Differences in Treatment Motivation, Stigma, and Disclosure
As shown in table 4, there is no significant difference found in treatment motivation and coping strategies between male and female patients. Similarly, stigma and disclosure were significantly higher in female as compared to male patients.

Table 4 Compare of the gender differences treatment motivation, stigma, and disclosure

| Variable               | Male $(n = 222)$ M (SD) | Female $(n = 65)$ M (SD) | $T$    |
|------------------------|-------------------------|--------------------------|--------|
| Treatment Motivation   | 102.6 (9.1)             | 104.4 (10.3)             | -1.36 *** |
| Stigma                 | 53.7 (5.9)              | 57.4 (6.3)               | -4.38 ** |
| Disclosure             | 117.4 (11.3)            | 121.7 (12.4)             | -2.64 ** |

*Note:* *** sig. ≤0.001 and * sig. ≤0.05, CI = Confidence Interval, LL= Lower Limit, UL = Upper Limit, df = 285

4.5 The comparison of treatment motivation, stigma and disclosure between married and unmarried patients
As shown in table 5, the level of treatment motivation is almost equal between married and unmarried HIV patients. Similarly, stigma and disclosure were significantly higher in unmarried patients than those of married patients.

Table 5 Compare of treatment motivation, coping strategies, stigma and disclosure between married and unmarried patients

| Variable               | Married $(n = 90)$ M (SD) | Unmarried $(n = 197)$ M (SD) | $T$    |
|------------------------|---------------------------|------------------------------|--------|
| Treatment Motivation   | 102.7 (9.6)               | 103.1 (10.1)                | -0.32  |
| Stigma                 | 52.7 (7.2)                | 55.9 (6.3)                  | -3.81 *** |
| Disclosure             | 116.4 (10.3)              | 119.8 (9.8)                 | -2.68 ** |

*Note:* *** sig. ≤0.001 and ** sig. ≤0.01, CI = Confidence Interval, LL= Lower Limit, UL = Upper Limit, df = 285
5. Discussion

The present study explored the relationship between treatment motivation, stigma and self-disclosure among people living with HIV/AIDS in Pakistan. We found that female patients had higher levels of stigma and disclosure. Meanwhile, unmarried patients had higher levels of stigma and disclosure. Previous studies suggested that men living with HIV delay seeking treatment and receive treatment at an advanced stage of HIV infection, which makes them predisposed to increased death rates and worse treatment consequences (Shisana, Olive 2004). In contrast, female patients with HIV had the higher treatment and coping motivation as compared to male patients because female patients had positive coping such as acceptance, avoidance to escape and responsibility (Silva et al., 2018). In our study, no significant difference in treatment motivation and coping with HIV positive found between male and female patients. However, in the present study, we identified that female patients experienced more stigma as compared to male patients. The reasons given relate to HIV diagnostic disclosures and are also closely linked to socially recognized norms on gender roles, sexuality and responsibilities. In this context females are considered as the transmitters of HIV; hereafter, when they tested positive for HIV, they blamed HIV more than men. In the dominant male society of Vietnam, women experienced blame more than men (Hong et al., 2004). Our findings in the present study are, female living with HIV in Pakistan face significant stigma and more disclosures. The results imply that it should be noted the culture difference when considering the treatment motivation of patients with HIV positive. These findings are consistent with our study held by (Gladys et al., 2014) showed the same outcomes to present results and showed a higher level of female stigma as compare to male HIV patients.

Study shows that poor married people have a lower HIV prevalence rate than the poor unmarried people, and the other side wealthy married people's HIV prevalence is higher than that of wealthy unmarried people. The present study found that unmarried experienced more stigma and self-disclosure compare with married patients. The possible cause of the results may be that participants are less likely to reveal their HIV status to their spouses, so for those who live with their spouses, they may be under enormous pressure to keep their HIV status secret, leading to a higher level of HIV-related stigma. However, the risk of HIV did not differ between married and unmarried. These finding supported with the previous study (Shisana, Olive 2004).

Previous studies by (Lyimo et al., 2014) found that the correlation of stigma and disclosure with treatment. It also posited in a study that disclosure asserted with some positive treatment-related outcomes, due to motivating patients for treatment after perceiving the status of their disease (Toth, Messer, & Quinlivan, 2013).

6. Conclusion

The study concluded that stigma, disclosure and treatment motivation are significantly correlated with each other. Furthermore stigma, and disclosure leads to treatment motivation of patients with HIV positive. The results showed that treatment motivation, stigma and self-disclosure significantly higher in female HIV/Aids patients than that of male HIV/Aids patients. It was also found that stigma and self-disclosure significantly higher in unmarried HIV/Aids patients than that of married HIV/Aids patients.

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