DEPRESSION AND COPING: A STUDY ON HIV POSITIVE MEN AND WOMEN

A.G.Shanthi [a], J.Damodharan [b], Priya. G [a]

ABSTRACT

Aim of the study: *This study is aimed at evaluating the level of depression and coping pattern in HIV positive patients.*

Methodology: *51 newly diagnosed HIV patients (M = 34 / F = 17), were selected for the study from the HIV Clinic, SRU. Hamilton Depression Rating Scale and Ways of Coping were used to evaluate the levels of depression and to identify their different coping styles. Descriptive and Inferential statistics were used to analyze the data.*

Results: *Statistical analysis based on ANOVA indicates no significant difference in the level of depression in relation to gender; mean scores reveal severe level of depression in all patients included in this study. Among the 8 types of coping, there is significant difference in Confrontative coping, Seeking social support, Accepting responsibility ($p = <0.001$) and Escape-Avoidance, Self control ($p = <0.005$) in relation to gender; where men tend to escape or avoid circumstances, whereas women seek more social support*

Discussion: *Retro-positive patients have severe depression. Women face lot of conflicts, as they are more responsible in maintaining relationships in the family; whereas men deny or they feel guilty of their illness or high-risk behaviour and are more concerned about financial issues. It is evident that their coping styles are maladaptive in nature. Men escape from problem situations; they try to control the situation or people around them. They also try to detach and distance themselves from stressors. Women seek support from others in the family or society and they too avoid or detach conflicting situations. It is evident that both men and women do not try to cope by accepting responsibility, planning and solving the problems or through positive reappraisal for improving or maintaining their personal growth.*

Key words: *Psychological adaptation, HIV, Depression*

INTRODUCTION:

HIV/AIDS is a major concern and has only recently attracted the attention of psychosocial research, especially among subjects at higher risk. A number of clinical psychiatric syndromes have been identified in relation with HIV infections. As with any other life threatening illness, the HIV patient must adapt to a set of disease specific factors such as medical, psychological and social as well as the general threat of death. All these factors may often lead to various psychiatric conditions like anxiety and depression; and they tend to adapt maladaptive coping styles. These patients may not recognize or report depressive symptoms. Instead they may present with behavioural changes, which may indicate the presence of underlying depression.

In a meta-analysis people with HIV were twice as likely to to be diagnosed with major depressive disorder than those with HIV seronegativity(1). A study of 100 AIDS patients depicted that the depressive disorders were more prevalent among female patients and they also had more prominent psychosocial problems(2). Studies have also reported a link between passive coping strategies (e.g., denial) and HIV-1 disease progression. Coping by means of denial was found to correlate with lower CD4 count(3).

CORRESPONDING AUTHOR :

Ms. A. G. SHANTHI,
Lecturer, Department of Clinical Psychology
Sri Ramachandra University, Chennai.
email: shanthiags@yahoo.co.in
[a] Department of Clinical Psychology
[b] Department of General Medicine

The role of depression in HIV-1 disease progression has been examined. Seropositive men showed that baseline depression was associated with faster progression to AIDS (4) and that elevated depression at every visit increased the risk of mortality (5). Baseline measure of depression can vary and produce inconsistent results due to other moderating factors (e.g., coping, social support, premorbid vulnerability) (3). Studies reported one of the first prospective findings that stressful events and social support were related to HIV-1 disease progression to AIDS (6). Conscientiousness was related positively to medication adherence and active coping and negatively to depression, avoidant coping and perceived stress (7).

A study showed that greater health worries, less comfort with how one contracted HIV, more HIV-related symptoms, less social support, and lower spiritual well-being was associated with significant depressive symptoms (8). Psychiatric morbidity, coping responses, and disability in male and female outpatients recently diagnosed with HIV/AIDS, showed no significant gender differences in the prevalence of mood disorders. Men, however, were more likely than women to meet diagnostic criteria for alcohol abuse or dependence, and to engage in certain risky sexual behaviours. Women were more likely to suffer from post-traumatic stress disorder, and to use coping strategies of planning and religion to deal with the illness (9).

Although there is growing literature on the psychological responses and the psychopathology associated with HIV/AIDS, few investigations have focused on the role of gender. Thus this study was aimed to evaluate the level of depression among retropositive male and female patients and their coping styles.

MATERIALS AND METHODS:

The present study hypothesizes that there will be significant difference between male and female patients in their level of depression and coping styles. The sample consists of 51 newly diagnosed Retropositive patients, including both males (N = 34) and females (N = 17). They were selected through purposive sampling, from the HIV clinic, SRU after being diagnosed by the concerned physician. The age range of the sample is 20 to 50 years. Past history and family history of mental illness is excluded. After a month of diagnosis and post-test counseling, informed consent was obtained and their socio demographic details were collected.

Later the following assessment tools were administered in 2 sessions (during monthly follow up).

- Hamilton Depression Rating Scale (HDRS) – is a 24 item scale developed by Max Hamilton (10). The clinician rates and scores (as per the manual). The level of depression is interpreted based on the scores obtained; where Normal is 7 and below, Mild is 8 to 13, Moderate is 14 to 18, Severe is 19 to 22, and Very severe is 23 and above.

- Ways of Coping – is a 66 item questionnaire developed by Lazarus and Folkman (11). The scale consists of 8 types of coping viz., Confrontative Coping (CC), Distancing (D), Self Control (SC), Seeking Social Support (SSS), Accepting Responsibility (AR), Escape – Avoidance (EA), Planful Problem Solving (PPS) and Positive Reappraisal (PR). Raw scores for each subscale is converted to a relative score and is interpreted based on ranking method (as per the test manual). Hence, lesser the score indicates that the individual adapts that particular ways of coping more than other coping styles.

Descriptive Statistics and ANOVA were used to analyze the collected data.

Results:

Table 1 shows the socio demographic details of the sample. The selected sample consists of 34 males and 17 females. The majority of the group falls in the age range between 31 to 40 years and most of them belong to low socioeconomic status with education up to high school. Majority of the sample population are married, many accepted the presence of high-risk behaviours and reported of opportunistic infections.

Figure 1 gives the graphical representation of the mean scores of depression and various coping styles among male and female patients. The mean score shows that females have higher level of depression when compared to male patients. The low means scores of the sub scales of coping indicate that the sample population highly tend to Escape or Avoid, Confrontate, Seek Social Support or Distance themselves as part of their coping style. It is evident that men tend to cope more by Escape Avoidance, Confrontative Coping and Distancing; whereas women tend to cope by Seeking Social Support, Escape Avoidance and Distancing.

Table 1: Frequency and Percentage Distribution of the Demographic details of HIV positive patients

VARIABLES		Frequency	Percentage
Sex	Male	34	66.7
	Female	17	33.3
Age	20 – 30 years	19	37.3
	31 – 40 years	24	47.0
	41 – 50 years	8	15.7
Education	< 10th std	39	76.0
	< 12th std	6	12.0
	Graduation	6	12.0
Socioeconomic Status	Low	34	66.7
	Middle	17	33.3
Marital Status	*Married*	*41*	*80.0*
	Single	*6*	*12.0*
	Separated	*1*	*2.0*
	Widowhood	*3*	*6.0*
Spouse HIV Status	Positive	18	40.0
	Negative	12	26.7
	Not Known	5	33.3
Family Support	Present	34	66.7
	Absent	17	33.3
High-risk Behaviour	Present	24	47.0
	Absent	14	27.5
	Denied	13	25.5
Opportunistic Infections	Present	36	70.6
	Absent	15	29.4

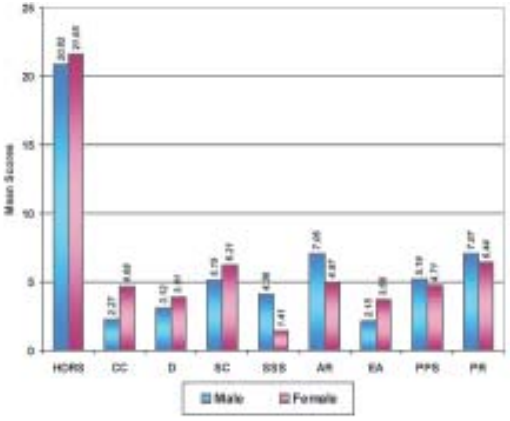

Figure 1: Mean scores of Male and Female patients on Depression and Various Ways of Coping

(HDRS – Hamilton Depression Rating Scale, CC – Confrontative Coping, D – Distancing, SC – Self Control, SSS – Seeking Social Support, AR – Accepting Responsibility, EA – Escape Avoidance, PPS – Planful Problem Solving, PR – Positive Reappraisal)

Table 2 shows that there is significant difference between males and females in Confrontative Coping, Seeking Social Support and Accepting Responsibility ($p = < 0.001$); Escape Avoidance and Self Control ($p = < 0.005$). There is no significant difference between men and women in their level of Depression, Distancing, Planful Problem Solving and Positive Reappraisal.

Table 2: Summary of ANOVA on Depression and Various Coping Styles of HIV positive patients

Variables	Source of Variation	df	Sum of Squares	Mean Square	F	Sig.
Depression (HDRS)	Between Groups	1	7.686	7.686	1.590	.213
	Within Groups	49	236.824	4.833		
	Total	50	244.510			
Confrontative Coping (CC)	Between Groups	1	65.922	65.922	34.150	.000**
	Within Groups	49	94.588	1.930		
	Total	50	160.510			
Distancing(D)	Between Groups	1	7.147	7.147	1.813	.184
	Within Groups	49	193.147	3.942		
	Total	50	200.294			
Self Control (SC)	Between Groups	1	12.706	12.706	9.252	.004*
	Within Groups	49	67.294	1.373		
	Total	50	80.000			
Seeking Social Support (SSS)	Between Groups	1	79.412	79.412	48.338	.000**
	Within Groups	49	80.500	1.643		
	Total	50	159.912			
Accepting Responsibility (AR)	Between Groups	1	49.422	49.422	15.077	.000**
	Within Groups	49	160.618	3.278		
	Total	50	210.039			
Escape Avoidance(EA)	Between Groups	1	26.510	26.510	10.456	.002*
	Within Groups	49	124.235	2.535		
	Total	50	150.745			
Planful Problem Solving (PPS)	Between Groups	1	2.669	2.669	1.108	.298
	Within Groups	49	118.037	2.409		
	Total	50	120.706			
Positive Reappraisal(PR)	Between Groups	1	4.532	4.532	3.732	.059
	Within Groups	49	59.507	1.214		
	Total	50	64.039			

** Significant at the 0.001 level (p = < 0.001)* Significant at the 0.005 level (p = < 0.005)

DISCUSSIONS:

Depression: The total mean score of the sample population indicates severe level of depression (10). Mean scores reveals that females have more depression than males, though the difference is not statistically significant. This difference may be due to societal and cultural expectations from women as a wife and mother are highly demanding. Mothers play a major role in child rearing especially breast-feeding and are also worried about their family after their death. Feelings of guilt are also present as they are unable to take care of themselves and the family, which results in helplessness, hopelessness and worthlessness (2, 8, 12).

Depression in men is also evident due to fear of death, helplessness and guilt feelings which are prominent as most men have high-risk behaviours and that they are the cause of transmission within the family. During the depressive phase more concern is focused on how to inform and face the family members rather than on how to manage themselves with the illness (4). Financial burden is also a contributing factor for depression in men (13).

Coping: Coping styles can be adaptive or maladaptive in nature and it differs in each individual, depending on the stress experienced by the individual. Each coping style is discussed as per the total mean score obtained by the group (Figure 1 and Table 2).

The following coping styles have significant difference in relation to gender.

Confrontative Coping: They may take risk and try to alter the problem situation or change other's mind and accept responsibility rather than by facing the problem. Men tend to get hostile towards problems; which may be due to lack of support. They express their anger towards their family members even though they are not the cause (12, 14).

Seeking Social Support: Women seek support from family members and at times even from the medical team in order to deal problems related to illness (e.g. controlling or advising husband, issues related to children, etc). Men seek less support and have greater use of denial due to various stressful life events (3). Both seek social support from people

of their personality trait or characteristics (e.g. women seek support from those who blame her husband and men from those who have similar problem or high-risk behaviour) (6, 12, 14).

Accepting Responsibility: Men tend to deny, but some women are forced to accept their mistakes on the basis of religion (3). In crisis situation women are able to take up the role of a man by supporting the family financially; whereas only few men take up such familial responsibilities.

Escape – Avoidance: Men tend to cope by escaping, avoiding and confrontative coping when compared to other styles, which may be due to the phase of denial on the part of the patient after being diagnosed (3, 12, 15). There is less need to seek support from others, as they tend to avoid problematic issues (7, 16). They are unable to face the problem, as they may be blamed for their risk behaviours. Women avoid or escape by blaming others. Men try to escape by smoking or consuming alcohol; some may even involve more in high-risk behaviours (9).

Self Control: Men try to control their actions and behaviour in order to avoid problem situation. They hide their feelings and do not want to reveal their HIV status to others (17). They fear rejection, has poor social interaction, leading to depression.

There is no significant difference between males and females in the following types.

Distancing: Both men and women try to detach and distract themselves from the actual problem (3). They tend to reduce the importance of the situation in order to avoid the distress faced by the individual. They tend to attribute their problems to fate or sin.

Planful Problem Solving: All patients were found to use this coping style rarely (18). Among them women use this strategy more than men, in order to analyze the ways to live with their illness and face the consequences (9).

Positive Reappraisal: Women tend to emphasize on religious aspects, tries to cope with their spiritual beliefs (9, 19). They rarely try to change themselves or aim for personal growth. As this illness is not curable, they believe that nothing can be improved by changing themselves.

Both men and women with HIV infection use Planful Problem Solving (19) and Positive Reappraisal the least, as it requires high sophistication of adaptive coping strategy.

CONCLUSION:

There is severe level of depression present in retropositive patients. No statistical difference is evident between males and females. The sub types in coping indicate that patients use more of maladaptive coping strategies like escaping, avoiding, controlling self and others. The sample population does not use adaptive coping styles like positive reappraisal, planning and problem solving.

This study highlightens certain clinical features of HIV infection, which generally goes unnoticed. Further investigation on other psychosocial variables and the efficacy of psychological management is planned to reduce the level of depression and ameliorate their ways of coping.

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