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REVIEW ARTICLE ON THE PSYCHOLOGICAL ASPECTS OF PEOPLE LIVING WITH HIV AND AIDS

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Abstract:

The majority of patients with serious, progressive illnesses deal with a variety of psychological difficulties, such as the possibility of actual and projected losses, declining quality of life, the fear of physical deterioration and death, and managing ambiguity. Because of the fast evolving treatment breakthroughs and outlook, having HIV or AIDS poses significant difficulties. Additionally, this illness is exceptional due to the severity of the stigma attached to it and the fact that HIV can be both contagious and lethal. The danger of transmission necessitates significant and long-lasting adjustments in sexual behaviour and/or the control of substance use, neither of which may be amenable to simple change. We summarise the psychological problems and difficulties of living with HIV infection, the psychiatric conditions that are frequently seen, the ways primary care physicians can assist in addressing these problems, and recommendations for when they should think about enlisting the aid of mental health professionals and other support services.

Keywords: Psychological, HIV, AIDS, Depression, Psychosis, Mental Illness

INTRODUCTION

Introduction:

The epidemic of the human immunodeficiency virus (HIV) was first discovered in the 1980s (14). 39 million people have died from AIDS-related causes since the epidemic's inception, while an estimated 78 million individuals have contracted HIV. In order to reduce the impact of the HIV/AIDS epidemic, many HIV/AIDS prevention techniques and policies have been developed (3, 5). To combat this chronic condition, prioritised interventions are being used in Ethiopia. One of the top priorities is HIV/AIDS chronic care, which includes giving ART to every HIV-positive person, regardless of CD4 level or WHO HIV/AIDS staging, to help them live longer and with better quality of life. The first ART treatment started in 2003, and Ethiopia launched its free ART programme in 2005. There are more than 1230 medical establishments offering HIV care and treatment services at this time (3). Psychological issues have been identified in up to 50% of people with particular medical conditions or stressors (14)

The public health hazard posed by the acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) continues to be catastrophic and has reached crisis levels among young individuals. As a biological, psychological, and social issue, HIV is a significant global hazard to children and adolescents. Children with HIV infection and AIDS are becoming more prevalent. The Joint United Nations Programme on HIV/AIDS UNAIDS estimates that there are 2 million AIDS orphans in India, making it the country with the highest number. According to estimates, vertical transmission is responsible for nearly 4% of the 2.4 million HIV infections in the nation among children. Despite a notable decline in vertical transmission as a result of a strong emphasis on preventing parent to child transmission (10), new HIV infections in children are still being identified.

When a test can identify HIV in your body, it is referred to as the window period for an HIV test. Depending on the HIV test type utilised, a window period applies.

- Usually, 23 to 90 days after exposure, HIV can be found using antibody tests. The majority of quick tests and self-tests use antibodies.
- 18 to 90 days after exposure, HIV may typically be found with a quick antigen/antibody test using blood from a finger stick.
- 18 to 45 days after exposure, HIV may typically be found via an antigen/antibody lab test utilising blood from a vein.
- 10 to 33 days after exposure, a nucleic acid test (NAT) can typically detect HIV(32)

It is well recognised that those who are living with HIV/AIDS (PLWHA) have significant emotional requirements and need a lot of help in order to accept their serious illness status. One of the emotions that PLWHA experience is shock or anger when receiving a positive HIV diagnosis. Other emotions include fear of the disease's progression, fear of being abandoned by family and friends, and concerns about spreading the disease to others. It is not shocking that depression is twice as common in PLWHA as it is in the general population due to carrying such a hefty emotional weight (15).

Additionally linked to HIV/AIDS-risky behaviours, non-adherence to HIV/AIDS-related medications, and decreased survival rates are psychosocial issues (23). Despite the fact that psychosocial distress is regularly experienced by PLWHA, the body of data suggests that depression is usually underdiagnosed and frequently goes untreated (24). Some people may believe that the world has come to an end and that there is no hope for the future after learning they have HIV, while others may view the news as a stepping stone to a better life.

True, living with HIV can be made simpler with the right support and care. But without that, the outcomes might be disastrous. One of the reasons for this is that individuals with HIV (PLHIV) who undergo emotional and mental stress may develop a variety of psychiatric issues (22).

There is a heavy psychological cost associated with HIV/AIDS. As they cope with the effects of receiving an HIV diagnosis and deal with the challenges of having a chronic illness, PLHIV frequently experience despair and anxiety. Living with HIV is difficult because it is accompanied by numerous important and frequent stresses, such as physical suffering, ART side effects, social stigma, and discrimination (25).

The leading causes of years spent living with a handicap in the general population are mental and drug use disorders, which have a bigger impact than other communicable, maternal, neonatal, nutritional, and non-communicable diseases, including HIV, and injuries (4). Both direct and indirect paths can enhance the risk of HIV acquisition in people with mental health issues (11, 26). Additionally, the degree of psychiatric disease may raise the chance of HIV infection(7).

Multiple co-occurring disorders, such as a mood disorder, substance use disorder, and posttraumatic stress disorder from (for instance) physical, sexual, or emotional abuse, may increase the risk of HIV(6). The word "mental distress," sometimes known as "psychological distress," refers to a variety of internal experiences and symptoms that are typically seen as upsetting, perplexing, or unusual. Some psychiatric symptoms, like anxiety, conflicted emotions, hallucinations, wrath, despair, and others, may be displayed by a person who is experiencing mental distress (18).

Psychological aspects of living with HIV:

Some patients seem to experience no psychological impact from their illness. Depression, anxiety, and hostility were moderate and unrelated to physical disability in long-term AIDS survivors. However, the degree of physical disability was correlated with a sensation of helplessness, even if this experience of helplessness was very minor. Psychological fortitude and successful survival emerged as the overarching topic (28). In a large portion of the psychology literature, it has been presupposed that obtaining an HIV positive test result may trigger depressive disorders, symptoms of post-traumatic stress disorder, or other psychiatric symptoms, as well as the need for psychiatric or psychological treatment(2). Patients are more susceptible to acute distress at certain stages of HIV disease, such as when they first learn they have the virus, when their first physical symptoms appear, when their CD4 cell count suddenly drops, when they contract their first opportunistic infection, or when they are admitted to the hospital for the first time. For both patients and carers, holding onto hope as the course of the illness advances is a significant psychological burden.

Distinguishing between normal degrees of distress during stressful circumstances and psychiatric problems that require extra care is necessary.

Depression:

Among HIV-positive patients, depression is the most prevalent psychiatric condition. whereas early data based on clinical observation or analyses of medical records suggested substantial rates of distress and depressive symptoms among persons with HIV or AIDS (30,31).Up to 98.6% of HIV patients report having emotional issues, making them one of the most prevalent symptoms. In addition to being a well-known adverse effect of NRTI, Protease inhibitors, and NNRTIs, depression is a common comorbidity associated with HIV infection. It might potentially be the initial sign of an HIV case.It is crucial to distinguish between a person's typical reaction to a life-threatening sickness, an HIV clinical presentation, and a depressed episode while also acknowledging that all three conditions can coexist. Anhedonia may be the most accurate sign of severe depression, just like other major medical conditions. It is known that HIV-positive people who learn they are seropositive have a high risk of suicide during that time, especially if they have a history of mental illness.Depression is frequently linked to chronic pain, which is common in HIV patients and can be brought on by both the disease and its treatment side effects (13).

Mental illness:

Mental and emotional illnesses are closely related to the psychological effects of HIV. Around the world, 10-20% of children suffer from mental health problems, which are among the leading causes of health-related disability. These diseases are also a precursor to various morbidities and mental health issues in adults (25)

Untreated mental illnesses may result in more deaths than are officially reported. It is well known that persons who have HIV/AIDS have significant emotional demands and need a lot of help to cope with their serious illness status. In order to diagnose and treat these impacts, it is crucial to have a deeper understanding of their mental and emotional effects. Compared to adults, children and adolescents living with HIV may experience a greater burden of behavioural and mental health difficulties. Access to mental health services, the importance of mental health issues in the transition from paediatric to adult care services and responsibilities, and the effects of mental health therapies are some other difficulties that young people experience (17).

Anxiety disorders:

Disorders of anxiety can occur before HIV infection or as a result of it. Psychiatrists should use normal pharmacologic treatment for anxiety disorders with caution because the treatment of anxiety disorders in HIV-infected patients has not been adequately explored. For instance, a number of benzodiazepines are contraindicated in patients using protease inhibitors, especially ritonavir since projected pharmacokinetics show that blood levels of these psychiatric medications will be significantly increased. Therefore, benzodiazepines should often be a short-term intervention (9).

Stigma and discrimination:

Another issue that the patient suffers when exposing his or her status is the stigmatisation and prejudice that result(29), which frequently restricts alternatives for marriage, job, and may even cause divorce. A common contributing factor to patients developing a serious fear of disclosure, which can be disastrous, is the stigma and discrimination associated with HIV.

HIV-related stigma is a major problem that has an influence on adolescents who are living with the virus in low- and middle-income countries by lowering their quality of life, their access to healthcare, and the standard of the medical care they receive. Significant obstacles to HIV treatment include stigma and prejudice in both the community and inside clinics, which can have negative effects and lead to poor drug adherence. Furthermore, stigma related to HIV frequently overlaps with stigma related to other conditions, such as those connected to substance use or mental health issues. Two prevalent diseases linked to HIV, such as depression and anxiety, already carry stigma.As a result, stigmatisation is said to be increased for someone who has HIV plus a mental illness(8).

Fear and loss:

The most fundamental of fears—fear of our own mortality—is directly related to the fear of HIV/AIDS. Most of us are fighting this dread by constantly avoiding the thought of suicide or by coming up with a variety of consoling notions. The only thing that escape and justification will do is increase our fear of dying.

People with advanced AIDS worry about losing their lives, their goals, their physical ability and potency, their sexual relationships, their social status, their financial security, and their independence. They lose their sense of privacy and control over their life as a result of the growing systematic propensity and essential necessity. The decline in confidence may be the most severe concern. Future effects, worry resulting from a connection with a loved one or carer, and unfavourable social reactions are all possible.

Guilt and self-esteem:

The risk of infecting others or from the prior manner of living that contributed to the infection, shame is frequently felt after receiving a diagnosis of HIV/AIDS. A sense of responsibility for what disease does to one's own family members, particularly children, is also present. The patient may experience even stronger feelings of wrongdoing if past incidents that caused others' suffering or misery stay unresolved and recur.

People with HIV/AIDS who must deal with their complicated destiny frequently lose their self-esteem very quickly. Loss of self-esteem and social identity, which results in the perception of one's own worthlessness, can occur very fast as a result of rejection from coworkers, relatives, loved ones, and frequently other people. The deterioration of disease-related symptoms, such as facial deformity, physical degeneration, loss of strength, and loss of control over one's body, might exacerbate this illness (12).

Cognitive deficits:

Significant cognitive abnormalities in patients with advanced HIV illness in India who are not receiving HAART have been described. In one study, it was found that 56% of PLWHA had cognitive impairment in at least two areas (21). Given the

implications for how neurocognitive impairments in silent HIV infection may affect vocational competence, this topic has attracted scientific attention. There have been reports of cognitive impairments in 60–90% of HIV-positive asymptomatic persons (19). Present this as a potential explanation for the variation in the severity of HIV-1-related neurological impairments in India. Dementia and severe AIDS make people more susceptible to delirium, which is common with HIV. In addition to alcohol withdrawal, other medicines used in therapy, diarrhoea, hypoxia brought on by pneumocystis carini infection, CNS infections, and diarrhoea may all be factors. One should also inquire about the use of complementary therapies or traditional medicines that may exacerbate delirium in the Indian environment (16).

Psychosis:

Primary or secondary psychotic symptoms may be seen in HIV-infected people (16). Sometimes the signs of an HIV infection may manifest as psychotic symptoms (27). While secondary psychosis frequently occurs alongside global (encephalopathy) or localised pathology (most frequently lesions of the left temporal lobe and diencephalon), primary psychosis does not show any symptoms of HIV cerebral illness.

Opportunistic diseases such tuberculoma, toxoplasmosis, and cryptococcal meningitis need to be taken into account in the differential diagnosis because they can initially manifest as severe psychosis. Psychosis may also result from the use of drugs like INH or from having neurosyphilis concurrently. A rapid infection or hospitalisation might cause withdrawal-related psychosis in a number of people with concurrent substance use (20).

Conclusion:

HIV's psychological effects are primarily caused by a lack of understanding, care, support, and acknowledgment from family, friends, and healthcare professionals. Support from family and peers is crucial because it not only offers mental, financial, and social stability to those living with HIV and AIDS, but it also lessens the stress they experience.

As a result, it is advised that nations all over the world implement policies that take into account the social and economic requirements of people living with HIV/AIDS. It's crucial to involve more vulnerable communities, and you may do this by running awareness programmes that inform people about how HIV affects their mental health. NGOs also have a significant impact on people with HIV/AIDS in terms of their general health. It's important for mental health providers to understand the various psychiatric symptoms of HIV and how it may affect someone who already has a mental illness. Additionally, there are other issues that must be addressed, such as the effect of opportunistic infections on the brain, the toll that sickness takes on a person's life, the link between substance abuse and HIV, and the connection between therapy and mental health. In order to assess a patient with HIV, a psychiatrist must utilise systematic and varied procedures, take into account a variety of potential diagnoses, and be aware of any issues associated with the use of various medications. Specific problems include concomitant infections, IV drug use and stigma, insufficient HAART and palliative care facilities, and underdeveloped health care systems in impoverished nations like India all contribute to the burden of mental illness.

Ethical statement:

This study has no cruelty to humans or animals. Since, it is a review article, we did not took a subjects in this study.

Conflict of interest:

The above study describes the psychological aspects of people living with HIV and AIDS, and also provides the types of psychological complications faced by HIV and AIDS patients and what type of situations faced by society after knowing they have HIV and how it impacts on HIV patients.

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TABLE

Day 0	Infection that exists
Day 7-14	Viral load (95% within 3 days to 6 weeks, average 7 to 14 days)
Day 16	P24 antigen: 95% of persons develop p24 within 1 to 8 weeks, with a median p24 time of 16 days.
Seroconvesrion	7–21 days on average, 95% of persons have symptoms within 4 weeks for 70% of people.
Day 28	A 4th generation test reveals that 95% of individuals are antibody positive by day 28.
Day 90	By three months, around 99.97% of people have HIV antibodies and test positive.

Table.1: The Window Period For An HIV Test (1)