

# What They Think and Feel: an Exploratory Analysis of Heroin Addicts Having Diagnosis as HIV/AIDS

Zaeema Riaz Ahmad<sup>1</sup> and Riaz Ahmad

Institute of Clinical Psychology, University of Karachi,

**Abstract.** The present study was designed to explore the Pattern of thinking and feelings of drug addicts having HIV/AIDS regarding their disease and to measure the level of depression among them. A sample of 80 drug addict patients diagnosed as having HIV/AIDS were recruited from the record of the two rehabilitation centers of Karachi, Pakistan. A form related to demographic and personal information was filled in and a semi structured Interview was done. Siddiqui-Shah Depression Scale (Siddiqui, 1992) was also administered to measure level of depression among them. Descriptive statistics was applied to analyze the data. Findings reveal that mean age at the time of diagnosis of the study sample was 31 yrs. Majority of the patients had less than five years of education or were illiterate, 51 % of them also had Hepatitis as co morbid illness. Majority of the sample reported feeling hopeless, 66 % of the sample reported that they are concerned about themselves and 65% blamed themselves for the condition. 78% of sample's family members were aware about their illness out of which 58% reported to have disclosed it themselves. 75% of the sample was taking medications for their illness regularly. The study also revealed that patients, who reported anger towards their illness, were not taking medications regularly and whose family members got to know about the illness by someone other than the patient were more depressed. This exploratory study provides evidences of HIV/AIDS incidence in drug addicts and about their perception of disease and feelings. It also calls for further analysis of the factors that may influence the emotional wellbeing of drug addicts with HIV/AIDS.

**Keywords:** Depression, HIV/AIDS, Drug Addicts, Thinking and Feeling

## 1. Introduction

There has been an increased awareness regarding medical and social challenges associated with people living with chronic illnesses like HIV/AIDS. Around 90% of the AIDS victims are living in the developing countries where the incidence rate is aggravated by poverty, hunger, disease, lack of medical facilities, illiteracy and under-development (Bhurgri, 2006). The stigma attached to the illness has led many researchers to focus on co morbid psychological problems in this population. People with HIV experience shock or anger at being diagnosed, fear over how the disease will progress; they may have fear of isolation by family and friends, and worries about infecting others. By bearing such a heavy emotional burden it is not surprising that depression is twice as common in people with HIV compared to the general population (American Psychiatric Association, 2008). Several authors have reported depression as relatively more common in people with chronic illness as compared to general population (Evans et al., 1999; Morrison et al., 2002). Most of the symptoms of HIV like decreased sleep and appetite, fatigue, weight loss and somatic complaints are similar to depression and may increase the chances of depression in the HIV positive individuals and elevate the susceptibility of many depression rating scales (Drebing et al., 1994). In Pakistani context also it has been reported that majority of patients with hepatitis suffer from depression and anxiety (Dogar et al., 2009). Studies have also found high prevalence of depressive symptoms in patients with the diagnosis of HIV/AIDS and substance use disorders (Berger-Greenstein et al., 2007). Co-morbidity of psychological disorders with such chronic illness affects an individuals' ability to actively participate towards their treatment and recovery process thus creating interference in engaging in health promoting behaviors. Feeling of hopelessness and perception of lack of control on the chronic diseases like Aids is associated with depression in HIV-infected individuals (Rabkin et al., 1990; Kelly et al., 1993).

## 2. Method

---

<sup>+</sup> Corresponding Author. Tel.: +923022837731; Fax.: 0922134615369  
Email: zaeemasiddiqui@hotmail.com

## 2.1. Participants

For the purpose of present study, a sample of 80 drug addict patients diagnosed as having HIV AIDS were recruited from the two rehabilitation centers (i.e. New Horizon care center and Pakistan Society) for drug addicts of Karachi, Pakistan. All the participants were under treatment and belonged to lower socio-economic status.

## 2.2. Measures

**Siddiqui Shah Depression Scale (Siddiqui & Shah, 1992):** This is a scale developed to measure depression in both clinical and non-clinical samples of Pakistani populations. The reported reliability indexes reflect satisfactory psychometric properties of the scale. Split half reliabilities for clinical sample (Spearman-Brown correlation) were  $r = .79$  and  $r = .84$  respectively, while alpha coefficient is  $.91$ . For non-clinical samples  $r = .80$  and  $r = .89$ , respectively, while alpha coefficient is  $.89$ . The scale has significant correlations with various measures including Zung's Depression Scale, psychiatrists' ratings of depression and subjective mood ratings.

## 2.3. Procedure

After getting personal and demographic information, a semi structured Interview was conducted to know about the perception and history of participants' illness. Siddiqui-Shah Depression Scale (Siddiqui, 1992) was also administered to measure the level of depression among them. Descriptive Statistic (frequencies, mean, standard deviations and percentages) was computed through use of SPSS, Vol.12.

## 3. Results

Table 1: Demographic Characteristics of Sample

	<i>N</i>	<i>M</i>	<i>SD</i>
Age	80	35	9.33
Age at the time of Diagnosis (HIV)		31	8.72
Education			
Illiterate	36	45	
≥Grade Five	12	15	
≥Grade Ten	28	35	
≥Grade fourteen	4	5	

Table 2: Descriptive statistics of co-morbid illnesses

	<i>f</i>	<i>%</i>	<i>Depression Mean</i>	<i>SD</i>
<b>HIV</b>	39	49	70.34	23.38
<b>HIV &amp; Co-Morbid Hepatitis</b>	41	51	71.51	24.18

Table 3: Descriptive statistics of the first time reaction at the time of Diagnosis as HIV/AIDS

<b>Question</b>	<i>Response</i>	<i>f</i>	<i>%</i>	<i>Depression Mean</i>	<i>SD</i>
<b>What was your reaction when you got to know about your disease (HIV)?</b>	Anger	25	31	80.88	24.94
	Hopelessness	42	52	66.82	21.13
	Guilt	13	17	64.23	25.18

Table 4: Descriptive statistics of the first concern at the time of Diagnosis as HIV/AIDS

<b>Question</b>	<i>Response</i>	<i>f</i>	<i>%</i>	<i>Depression Mean</i>	<i>SD</i>
<b>When you got to know about your disease (HIV), who were you most concerned about?</b>	Self	53	66	72.76	23.29
	Family	19	24	69.47	24.92
	What others say	8	10	60.25	23.76

Table 5: Descriptive statistics regarding the fixation of responsibility for the HIV/AIDS

Question	Response	f	%	Depression Mean	SD
Who do you think is responsible for your condition (disease)?	Self	52	65	71.78	24.53
	Society	14	18	72.07	22.71
	Luck	14	16	66.50	22.25

Table 6: Descriptive statistics regarding the disclosure about having HIV/AIDS

Question	Response	f	%	Depression Mean	SD
Does your family know about your disease (HIV)?	Yes	62	78	71.51	24.73
	No	18	22	68.83	19.97
If 'Yes' did you tell them yourself	Yes	46	58	66.00	17.22
	No	34	42	73.27	26.00

Table 7: Descriptive statistics regarding the compliance with treatment for HIV/AIDS

Question	Response	f	%	Depression Mean	SD
Are you taking medicines regularly?	Yes	60	75	68.82	24.88
	No	20	25	77.05	18.69

#### 4. Discussion

Findings reveal that mean age at the time of diagnosis of the study sample was 31 yrs (Table 1). Regarding educational qualifications, majority of the patients were found to have less than five years of education or were illiterate (Table 1). Our study extends to the previous studies conducted globally indicating associations between more education, less risky sexual behaviour and less HIV infection for women in Yaounde' (Cameroon) and for men in Cotonou (Benin), but not in Kisumu (Kenya) or Ndola (Zambia) (Glynn et al., 2004). In Pakistani context it has been reported that efforts to increase awareness about HIV among the general population are hampered by low literacy levels and cultural influences (Preventing HIV/AIDS in Pakistan, 2005). **Many of the participants of our study also showed their concern regarding lack of knowledge and education related to their illness. Thus the incidence of HIV/AIDS increases with decreasing level of education.**

51 % (Table 2) of the sample diagnosed with HIV/ AIDS also had Hepatitis as co morbid illness. The results also indicate that there is no difference in the mean depression found in individuals having just HIV/AIDS or those having another chronic illness as co morbid such as Hepatitis. Having two infections can be more stressful as Yoon (2011) in his study found worst severity of depression in patients diagnosed with hepatitis C and HIV. However results of our study indicate that the diagnosis of just HIV/AIDS is enough to create hopelessness and depression in an individual. Majority of the sample (52%) reported feeling hopeless (Table 3) as their first reaction after knowing their diagnosis as compared to 31% feeling anger and 17% feeling guilt related to the illness. 66 % (Table 4) of the sample reported that they are concerned about themselves as compared to their family and what others might say. They (Table 5) blamed themselves for the condition as compared to blaming others for it. It is noticeable that those who felt anger towards their illness suffered from depression more as compared to those feeling hopelessness or guilt. Similarly individuals assuming the responsibility of illness on them were found to be more depressed as compared to those who blamed society or luck. Disclosing about one's illness such as HIV especially in a culture like Pakistan is a difficult task. In our study 78% (Table 6) of the sample reported disclosing their illness to others (family members and friends) by themselves. They suffered less depression as compared to those whose family members got to know about patient's illness by some other source. It was revealed through interview that many respondents feared stigmatization and adverse effect on their relationship with loved ones as the cause of not disclosing illness to others thus adding to their distress and vulnerability.

One of the important considerations to keep in mind is that patients with HIV/AIDS have low self image and feelings of hopelessness. Their hopelessness was linked to stigmatization; fear of death, fear of losing loved ones and lack of accessibility to healthcare services etc. Many of these patients had undergone

psychotherapeutic interventions and when while talking they became aware of how they got HIV infected which led to feelings of anger and frustration in them. Pakistan is a society where the religion forbids pre marital or extra marital sexual contact; thus the individual who is infected due to sexual behaviors may feel guilt, depression and anger.

Regarding compliance with treatment 75% (Table 7) of the sample reported taking medications regularly. They suffered from less depression as compared to those who were not taking medications. It may be that individuals a taking medication perceives themselves more in control or on the other hand depression is affecting their compliance with treatment. As one of the respondents reported that **‘I don’t feel the need to take medication. I don’t want to become better; there is nothing left in my life’**. Another reported that **“I prefer taking drugs as compared to medication when I think about my illness”**. Taking into account the effect of depressive disorder specifically it is manifested that the presence of depressive disorders often adversely affects functioning and well-being, compliance with treatment, course of illness, hence treatment outcome (Sherbourne et al., 2000; Chapman, Perry, Strine, 2005).

## 5. References

- [1] S. Siddiqui. The assessment of attributional Style of Depressive and non depressive through an indigenously developed depression scale. Unpublished doctoral dissertation, 1992, Quaid-i-Azam University, Islamabad-Pakistan.
- [2] Y. Bhurgri. HIV/AIDS in Pakistan. *Journal of Pakistan Medical Association*, 2006.
- [3] American Psychiatric Association, ‘Coping with AIDS and HIV’. 2008.
- [4] D. Evans, J. Staab, J. Petitto, M. Morrison, M. Szuba, H. Ward, and J. O’Reardon. Depression in the medical setting: biopsychological interactions and treatment considerations. *Journal of Clinical Psychiatry*, 1999, 60, 40-55.
- [5] M. Morrison, J. Petitto, T. Ten Have, D. Gettes, M. Chiappini, A. Weber, and D. Evans. Depressive and anxiety disorders in women with HIV infection. *American Journal of Psychiatry*, 2002, 159, 789-796.
- [6] C. Drebing, W. Van Gorp, C. Hinkin, E. Miller, P. Satz, D. Kim, and L. D’Ella. Confounding factors in the measurement of depression in HIV. *Journal of Personality Assessment*, 1994, 62, 68-83.
- [7] I. Dogar, N. Siddiqui, A. Bajwa, A. Bhatti, N. Haider, and Z. Hashmi. Relationship between liver diseases and levels of anxiety and depression. *Journal of Pakistan Psychiatric Society*, 2009, 6(2), 61-64.
- [8] J. Berger-Greenstein, C. Cuevas, S. Brady, G. Trezza, M. Richardson, and T. Keane. Major depression in patients with HIV/AIDS and substance abuse. *AIDS Patient Care STDS*, 2007, 21(12), 942-955.
- [9] J. Rabkin, J. Williams, R. Neugebauer, R. Remien, and R. Goetz. Maintenance of hope in HIV-spectrum homosexual men. *American Journal of Psychiatry*, 1990, 147, 1322-1326.
- [10] J. Kelly, D. Murphy, G. Bahr, J. Koob, M. Morgan, S. Kalichman, L. Stevenson, T. Brasfield, B. Bernstein, and J. St. Lawrence. Factors associated with severity of depression with human immunodeficiency virus (HIV) infection. *Health Psychology*, 1993, 12, 215-219. 23.
- [11] J. Glynn, I. Carae, A. Buve et al. Does increased general schooling protect against HIV infection? A study in four African cities. *Tropical Medicine and International Health* , 2004, 9, 4–14.
- [12] Preventing HIV/AIDS in Pakistan, **2005**, <http://go.worldbank.org/ZPV0G29CD0>.
- [13] J. Yoon, P. Crane, P. Ciechanowski, R. Harrington, M. Kitahata, and H. Crane. Somatic symptoms and the association between hepatitis C infection and depression in HIV-infected patients. *AIDS Care*, 2011, 1-11.
- [14] C. Sherbourne, R. Hays, J. Fleishman, B. Vitiello, K. Magruder, E. Bing, D. McCaffrey, A. Burnam, D. Longshore, F. Eggan, S. Bozzette, and M. Shapiro. Impact of psychiatric conditions on health-related quality of life in persons with HIV infection. *American Journal of Psychiatry*, 2000, 157, 248-254.
- [15] D. Chapman, G. Perry, and T. Strine. The vital link between chronic disease and depressive disorders. *Preventing Chronic Disease*, 2005, 2(1).