Chapter-III

Problem and Hypotheses
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PROBLEM AND HYPOTHESES

Acquired Immune Deficiency Syndrome (AIDS) is a viral disease that reduces the immune system's ability to defend the body against the introduction of foreign substances (antigens). Most researchers believe that HIV originated in sub-Saharan Africa during 20th century (Gao, Bailes, Robertson, Chen, Rodenbury, Michael, Cummins, Arthur, Peterson, Shaw, Sharp and Hahn, 1999). By that stage, the cases of HIV infections had been reported in every state of the country (Kaker and Kaker, 2001). The picture of HIV in India is equally worse. With a more than one billion population, around half of them are adults in the sexually active age group. The first case of HIV was detected in 1986, and until now, it is gradually increasing. Presently HIV infection has been reported to be prevalent in all states and union territories. The highest HIV prevalence rates are found in Maharashtra in the west, Andhra Pradesh and Karnataka in the South and Manipur and Nagaland in the northeast (NACO, 2006). The total number of AIDS cases reported as on 31st August 1997 were only 4846 and the rate of HIV infection was 21 per thousand (NACO, 1997), but in 2006, the total number of AIDS cases were 24 lacs and 70 thousand (NACO, 2006). In the world, now, India is the third highest in estimated people living with HIV. According to the HIV estimations 2012, the estimated number of people living with HIV/AIDS in India was 20.89 lakhs, with an estimated adult (age group 15-49 years) HIV prevalence of 0.27% in 2011. Children less than 15 years of age account for 7% (1.45 lakh) of all infections and 86% in the age group of 15-49 years. Of all HIV infections, 39% (8.16 lakh) are among women. The estimated number of PLHIV in India maintains a steady declining trend from 23.2 lakh in 2006 to 20.9 lakh in 2011. The four high prevalence states of South India (Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu) account for 53% of all HIV infected population in the country.
Although it seems on decreasing side but the number is too large, hence, may not be ignored.

At the beginning of 1990s, as the infection rates continued to rise, and until then, HIV had spread extensively throughout the country and rapidly expanding its paws across the world. It is a relatively new but highly disabling disease, which influences both the patients and the members of family and other acquaintances in a highly negative manner. The common perception about AIDS is that it is synonymous to death. Nations also bear very high cost of this disease. High prevalence and high incidence are the relevant causes to focus on the disease. HIV is taken mainly by biomedical factors and is explained in terms of medical approach. Earlier not or little attention was paid to the exploration of psychological factors in initiation, maintenance and treatment of the disease. Now, it is believed that infection of HIV has a great role in the development of psychological morbidity, and later on, these abnormalities affect the treatment procedure. Chandra, Desai and Ranjan (2005) reported that HIV infection could result in psychiatric disorders as psychological consequences of the infection.

Various psychotic syndromes or minor forms of psychological disturbance can be seen in the HIV infection at various points and may vary from one to another stage (Atkinson, Grant and Kennedy, 1988; Dew, Ragni and Nimorwicz, 1990), and the psychiatric symptoms occur as a reaction to the illness and the coexisting problems, or a part of neurological insult caused by virus, opportunistic infections, tumors, or metabolic disturbances as a result of coexisting infections (Goodwin and Jasmison, 1990). The impact of these factors on AIDS often leads to psychiatric symptoms such as anxiety, depression and even confessional states (Chandra and Ravi, 1995; Lyketsos, Hutton and Fishman, 1996; Perry, 1990). The symptoms of anxiety and depression are commonly encountered in patients with AIDS (Perry and Tross, 1984), and even in India, higher rates of anxiety and depression have been reported (Brown, Rundell and Mcmamis, 1992; Madan, Singh and Golecha, 1997). Depression is a significant problem among persons with HIV/AIDS. Ciesla and Roberts (2001) found a two folds increase in the prevalence of major depression in patients infected with HIV positive and HIV negative.
The psychological factors not only lead to psychological and psychiatric disorders but also affect the brain. High prevalence rates of suicide have been reported among HIV infected patients (Cournos, Empfield and Horwath, 1991; Grassi, 1996; Pugh, O'Donnell and Catalan, 1993; Weinharat and Carey, 1995). The prevalence of mania has been found to increase in patients with AIDS when compared with the general population (Holahan and Moos, 1987; Kieburtz, Zettelmaier and Ketonen, 1991). Sewell, Jeste, Atkinson, Heaton, Hesselink, Wiley, Thal, Chandler, Grant and HNRC Group (1994) found a prevalence rate of psychosis from 0.1 to 5% and most often in late stages of illness. These psychiatric symptoms are not only a problem on itself but also lead to many other problems that cause resistance to the treatment. Not only this but the psychiatric morbidity has become a leading cause to an increased potential for the spread of HIV epidemics as untreated patients with high viral loads are more infectious (Niccolo and Glenn, 2005). In India, it has been reported that because the deaths due to HIV infection are shrouded in stigma and secrecy, and incomplete funeral and death rituals, it acts as a risk factor for unresolved family grief (Chandra and Rao, 2000; Kamath, 1996). HIV infection in a family is associated with multiple losses (Bharat, 1996; Ankrah, 1993).

All this indicates that there is a need of psychiatric evaluation and management interventions for these clinical personality patterns. To plan interventions and to teach effective coping strategies, there is a need to know that which of the copings is better in case of HIV/AIDS patients. In HIV/AIDS literature, maladaptive coping has been associated with poor adjustment with HIV in various subpopulation of HIV-infected individuals including heterosexually infected women (Siegel, Gluhoski and Karus, 1997), gay and bisexual men (Billings, Folkman, Acree and Moskowitz, 2000) and drug users (Leiberich, Engeter, Olbrich, Rubbert, Schumacher, Brieger, Kalden and Joraschky, 1997). Folkman and Lazarus (1980) and McCrae (1984) reported that in disease related conditions, people mainly adopt emotion focussed coping as compared to problem focussed coping. Kabbash, El-Gueneidy, Sharaf, Hassan and Nawawy (2008) also found that HIV/AIDS patients mainly go with emotion-focussed ways of coping as compared to problem-focussed. So far as the effect of these strategies is concerned, Aldwin and Revenson (1987) found that avoidance, withdrawal and
substance abuse are usually associated with poor outcomes. Some other studies also indicated that problem coping strategies were related to lower mood disturbance in PLHIV, whereas, avoidance coping was associated with higher emotional stress (Grassi, Righi and Sighinolffy, 1998). Social support conceptualized as social integration (Berkman and Syme, 1994) or social discloser (Smythe, 1998) is usually associated with better mental and physical health outcomes, whereas, Monroe and Steiner (1986) reported that seeking social support is usually associated with poorer outcomes. Kobasa (1982) found that fewer avoidance coping strategies like denial showed less symptoms, whereas, Aldwin and Revenson (1987) found poorer outcomes due to emotion focussed coping. According to Nicholson and Long (1990), avoidance coping has also been associated with emotional stress. Considerable literature exists on coping in context of disease related stress and illness (Folkman, 1997) but the link between coping and immune function is controversial (Mulder, Antoni, Duivenvoorden and Kauffmann, 1999).

The research findings indicate that the studies pertaining to coping and the clinical patterns in the HIV/AIDS patients are available. Studies related to coping indicate that avoidance coping, social coping and denial coping strategies have been studied but all kinds of coping have not yet been covered in the existing literature on HIV/AIDS. These have not been studied collectively. Hence, it seems more relevant to study both the EFC and PFC ways of coping together on a larger sample of patients. At the same time, the difference in ways of coping adopted by HIV and AIDS patients is also not available in the literature. Further, there are many studies indicating that the clinical patterns of personality are found among HIV and AIDS patients. Here too, the major focus has been on anxiety, depression, suicidal tendency and mania/psychosis. Variables like antisocial features, borderline features and paranoia of different psychotic features separately have not been the focus of research. A careful look at the earlier literature has clearly shown a gap of information in this area. Only a few studies that have concentrated upon coping strategies were found in the literature. It is, therefore, important to study the clinical personality patterns varying because of different coping strategies adopted by different patients. This would be an important step towards designing the effective intervention.
strategies to deal with HIV. Therefore, the present study would concentrate on problem/emotion focussed ways of coping.

Keeping in view the above indications, the following problem was formulated.

**Problem**
To compare the clinical personality patterns amongst HIV and AIDS patients adopting emotion focussed and problem focussed ways of coping.

**Objectives**
1. To assess the ways of coping amongst HIV and AIDS patients
2. To compare the ways of coping amongst HIV patients with the ways of coping amongst AIDS patients
3. To understand the gender differences in the ways of coping amongst HIV and AIDS patients
4. To study clinical personality patterns amongst HIV and AIDS patients adopting emotion focussed and problem focussed ways of coping
5. To find out gender differences in clinical personality patterns separately in HIV patients and AIDS patients using EFC and PFC

**Hypotheses**
1. The use of emotion focussed coping would be more as compared to problem focussed coping amongst HIV and AIDS patients.
2. The AIDS patients would have a higher level of EFC than HIV patients.
3. There would be no significant gender difference in the ways of coping amongst HIV and AIDS patients.
4. The HIV and AIDS patients adopting emotion-focussed ways of coping would be significantly higher on the clinical personality patterns than those adopting problem focussed ways of coping.
5. No significant gender difference in clinical personality patterns amongst HIV and AIDS patients adopting emotion focussed or problem focussed ways of coping would exist.