THE PSYCHO-EMOTIONAL PROFILE OF THE HIV-POSITIVE NAÏVE PATIENT

Maria Alexandra Largu¹, Carmen Mihaela Dorobăţ², L. Prisacariu², Cristina Nicolau², V. Astărăstoae³, Carmen Manciuc²

University of Medicine and Pharmacy „Grigore T. Popa”- Iași
Faculty of Medicine
1. Ph.D. student
2. Discipline of Infectious Diseases
3. Discipline of Forensic Medicine

THE PSYCHO-EMOTIONAL PROFILE OF THE HIV-POSITIVE NAÏVE PATIENT (Abstract) Aim: The paper aims to outline the naïve HIV-positive patient’s profile, in terms of feelings and emotions post-diagnosis. Material and methods: The evaluation took place from January 2011 to December 2013 in the Psycho-social Assistance Office of the “Sfânta Parascheva” Infectious Diseases Hospital in Iaşi. We evaluated 146 patients newly diagnosed with HIV infection, both in terms of immunological and virusological and from a psychological perspective, using the Hamilton Anxiety Scale (HAMA), Beck Depression Inventory II (BDI) and the clinical interview. Results: In a period of 3 years (January 2011 - December 2013) we registered in the HIV/AIDS Regional Center in Iaşi, 146 new cases of HIV infection in adults, with distribution by years as follows: 46 in 2011, 45 in 2012, 55 in 2013; 39 cases were in Iaşi, 39 in Suceava, 26 in Botoşani, 18 in Neamţ, 16 in Bacău and 6 in Vaslui. Of these, 51 were women and 95 men, aged between 24 and 46 years. From the immunological point of view, 11% of patients had values of CD4 > 500 (16 patients), 47 % between 500 and 100 (69 patients) and 42 % < 100 (61 patients). From a psychological perspective, the clinical interview revealed a state of fear in 68.5 % of cases (fear of death, fear of complications, fear of other people’s reaction to the diagnosis), confusion in 62 % of cases (in terms of diagnosis, the mode of infection, the future), anger in 27 % of cases (against the source of infection, against themselves, against God or divinity), guilt and self-blame in 7 % of cases. Beck Depression Inventory (BDI) revealed moderate depression in 14% of patients; mild depression in 27% of patients and 58 % of patients presented no symptoms of depression. Regarding the anxiety scale HAMA, in 54 % of cases it showed mild anxiety, average anxiety in 28 % of cases, 14% severe anxiety and 3% (4 cases) very severe anxiety. Conclusions: Patients newly diagnosed with HIV are a vulnerable population with a specific psycho-emotional profile. Multidisciplinary knowledge - in medical, psycho –emotional and social terms – of the patient’s characteristics and needs helps to support adherence to the antiretroviral therapy and improve the quality of life. Keywords: HIV/AIDS, NAIVE PATIENT, PSYCHOLOGICAL PROFILE, ANXIETY, DEPRESSION

The newly diagnosed HIV-positive patient (also known as naive) represents a challenge for both infectious diseases doctor and psychologist, in terms of proper management. In order to best treat the patient, it is important to establish a relation-
ship based on the knowledge and the understanding of his needs, expectations, and his distinct psycho-emotional profile (1).

On receiving the HIV-positive diagnosis, the patient experiences a series of specific emotions: first, denial of the disease; then anger towards himself and others; this is followed by bargaining or “negotiation” of different aspects of the disease; after that comes the depression, the sense of “losing everything”; the last stage is acceptance, when the patient fully understands the HIV diagnosis and accepts it in his life (2). In most countries being HIV-positive is associated with stigma and discrimination, and that is why many patients feel that having contracted this disease is shameful and that it leads to social rejection – losing friends, social status, and ultimately their value as human beings (1, 2).

This is why the moment after the first HIV-positive diagnosis is critical in a patient’s evolution. It is very important that the infectious diseases doctor work with a specially trained psychologist that can offer support and guidance to the naive patient. The psychologist can help the patient fully understand the impact that HIV/AIDS will have on his social and personal life and can also offer assistance in coping with the antiretroviral therapy (ART). This is one of the most difficult aspects of living with HIV/AIDS – having to take ART for the rest of one’s life, and also coping with side-effects (3, 4).

In order to assist the newly diagnosed HIV/AIDS patient and to create the doctor-patient and psychologist-patient relationship, it is essential to understand the psychological and emotional profile of the patient. This paper aims to outline the naïve HIV-positive patient’s profile, in terms of feelings and emotions post-diagnosis.

**MATERIAL AND METHODS**

The evaluation took place from January 2011 to December 2013 in the Psychosocial Assistance Office of the “Sfânta Parascheva” Infectious Diseases Hospital in Iași.

 Newly diagnosed patients, also known as naïve patients, were evaluated in terms of immunological and virusological status and were also interviewed by the psychologist. After the clinical interview, they were also evaluated using the Hamilton Anxiety Scale (HAMA) and the Beck Depression Inventory II (BDI).

The Hamilton Anxiety Scale is one of the first rating scales developed to measure the severity of anxiety symptoms. It consists of 14 items, each defined by a series of symptoms. It is designed to measure both psychological anxiety (mental agitation and psychological distress) and somatic anxiety (physical complaints related to anxiety) (5, 6).

The Beck Depression Inventory is one of the most widely used instruments for measuring the severity of depression. It is a self-report inventory and it consists of 21 questions with multiple-choice (7, 8).

In a period of 3 years (January 2011 - December 2013) we registered in the HIV/AIDS Regional Center in Iași 146 new cases of HIV infection in adults, with distribution by years as follows: 32% in 2011, 31% in 2012, 37% in 2013 (fig.1).

**Fig. 1** Patient repartition in 3 years
The psycho-emotional profile of the HIV-positive naïve patient

Patients were admitted from all of the 5 counties in Moldova: 26.7% cases were in Iași, 26.7% in Suceava, 17.8% in Botoșani, 12.3% in Neamț, 10.9% in Bacău and 4.1% in Vaslui (fig. 2).

There was a higher percent of male patients – 65% men and 35% women (fig. 3), aged between 24 and 46 years.

RESULTS

From the immunological point of view, 11% of patients had values of CD4 > 500 (16 patients), 47% between 500 and 100 (69 patients) and 42% < 100 (61 patients) (fig. 4).

From a psychological perspective, the clinical interview revealed a state of fear in 68.5% of cases (fear of death, fear of complications, fear of other people’s reaction to the diagnosis), confusion in 62% of cases (in terms of diagnosis, the mode of infec-
tion, the future), anger in 27% of cases (against the source of infection, against themselves, against God or divinity), guilt and self-blame in 7% of cases.

Beck Depression Inventory (BDI) revealed moderate depression in 14% of patients, mild depression in 27% of patients and 58% of patients presented no symptoms of depression (fig. 5).

Regarding the anxiety scale HAMA, in 54% of cases it showed mild anxiety, average anxiety in 28% of cases, 14% severe anxiety and 3% (4 cases) very severe anxiety (fig. 5).

**DISCUSSION**

The number of new HIV/AIDS cases is continually increasing, with transmission mainly through unprotected sexual contact (homo- and heterosexual, prostitution) and use of unsterilized needles (drug users, tattoo and piercing) (9, 10).

In the North-Eastern part of Romania, the number of new HIV cases was large, with a rate of 35% per year, and many of the patients were in an advanced stage of the disease. The patients came from different backgrounds: multiple sexual partners, slow-progressers form the “pediatric cohort”, homosexual men.

From a psychological point of view, they all had common emotional patterns: fear or lack of perspective for the future, lack of respect for one’s self, sadness up to depression (11). Anxiety was high, and we believe this to be caused by both fear of dying and fear of social rejection.

A common emotion found in many of the patients in our study was guilt or shame. This is caused by a social phenomenon that associates HIV/AIDS with stigma, and leads to discriminatory behavior. In Romania, in spite of all the current existing information, AIDS is still, subconsciously, considered a shameful disease, contracted by marginalized populations that exhibit undesired behavior. With this in mind, the naive patient struggles to accept the positive diagnosis and not to consider him/herself as part of that discriminated group.

When establishing the best antiretroviral treatment, the infectious diseases doctor is obliged to offer the patient the best ART regimen catered to his or her needs. As specific as this treatment is, it only helps the patient at a molecular level. It is the psychologist’s task to support the moral and emotional process of accepting the HIV diagnosis and beginning ART (12). The psychologist’s expertise allows him to
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guide the patient through all the five stages of acceptance of the diagnosis. This will have long term impact on the patient’s adherence to therapy.

CONCLUSIONS

In our study, we highlighted the fact that patients newly diagnosed with HIV are a vulnerable population with a specific psycho-emotional profile.

Multidisciplinary knowledge - in medical, psycho-emotional and social terms – of the patient’s characteristics and needs helps to support adherence to the antiretroviral therapy and improve the quality of life.

The psychologist’s role is as important as the role of the infectious diseases doctor in managing the HIV-positive patient, due to his support and guidance in the continuous process of living with AIDS.

REFERENCES