ORIGINAL ARTICLE

SELF ESTEEM, QUALITY OF LIFE AND PSYCHIATRIC DISTURBANCES IN HIV POSITIVE DRUG DEPENDENTS ADMITTED AT A TERTIARY CARE HOSPITAL IN PAKISTAN

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ABSTRACT

OBJECTIVE
To examine the self-esteem, quality of Life and psychiatric disturbances in HIV positive Drug dependents in Pakistan.

STUDY DESIGN
Cross-sectional design.

PLACE AND DURATION OF STUDY
The study was conducted, in Model Drug Abuse; Treatment Center DHQ Hospital, Faisalabad, Pakistan from February 2016 to February 2017.

SUBJECTS AND METHODS
114 HIV positive drug dependents participated in the study through non-probability consecutive sampling, Demographic variable Proforma, Rosenberg Self Esteem Scale, WHO QOL BREF and Self Report Questionnaire -24 were administered.

RESULTS
Results showed that about half of the sample lived in urban areas, was married and started abusing drugs on peer pressure and there was significantly positive correlation among all four domains of QOL. One sample t-test confirmed that majority of sample had low self-esteem ($M = 11.25$, $SD = 4.32$), $t(113) = -9.26$, $p = 0.00$ and high psychiatric symptomatology ($M = 14$, $SD = 4.4$), $t(113) = 23.1$, $p = 0.00$.

CONCLUSION
HIV positive drug abusers belonged to special population segments like young males, uneducated daily wagers or unemployed. Most of the HIV positive drug abusers had low self-esteem and high psychiatric disturbances.

KEY WORDS
Psychiatric symptomatology, psychiatric co morbidity, mental health of HIV positive.

INTRODUCTION

In the form of HIV/AIDS, Pakistan is experiencing one of the foremost health dilemmas. Predominance of HIV is growing speedily, and people are subjecting to countless illnesses related to HIV/AIDS[1]. As in Pakistan relatively low number of HIV cases among general population are reported, UNAIDS identified Pakistan as a country of 'high-risk/low-prevalence. This conclusion is in line with most of the researches emphasizing susceptible population such as sex workers, people in need of treatment for sexually transmitted diseases and truck drivers[2].

HIV is transmitted via diffusion of infected body fluids such as semen, vaginal secretions and blood into the body of another person; this could happen either because of broken skin or mucous membranes, sexual activity, and use of contaminated tools such as syringes, non sterilized surgical and dental tools and other sharp instruments[3].

The risk of HIV/AID is amplified due to lack of awareness, limited access to information and treatment because of the stigma and social pressure is associated with it. Regardless of counseling many HIV+ patients belonging to conservative background do not reveal their illness with their family members and significant others. As a result in Pakistan majority of infants and adolescents were identified with HIV+ because of their infected mother or from infected blood transfusion[4]. Extensive studies show that individuals with drug dependence/substance use disorder are at the verge of indulging in risk behavior, thus drug use can cause the diffusion of HIV and other blood-borne pathogens through direct and indirect way[5,6]. Direct method includes use of contaminated syringes and needle sharing. The indirect methods include the cotton that is used to strain drug solution or the cooker which is used to melt or heat the drugs, use of single syringe to divide the solution among each injector can also transfer HIV[7].

The stigmatization and misconceptions associated with HIV/AIDS has implications for the mental health of people living with HIV/AIDS (PLWHA) [3]. For the comprehension and management of AIDS, psychosocial research is crucial[8]. Given the persistent and critical nature of this disease and the social stigma associated to it, quality of life (QOL) related to health, in addition to biological aspects, is a significant aspect of patients' well-being as it provides better perceptive of treatment efficacy and factors influencing considerable facets of patient's life,[9].

In relation to quality of life, self-esteem is a critical element in developing and sustaining optimism and wellbeing in patients with HIV/AIDS. Ample researches assert that low self-esteem can avert people with HIV/AIDS from progressing towards healing, taking care of themselves, thus developing feeling of hopelessness and doomed as they assume that they will die shortly [10]. Their feelings of anguish are escalated by the stigma, unawareness and often violence which may lead to social withdrawal or in some cases high risk sexual behavior [10-14].

Numerous studies of individuals under treatment assert that major mental disorders (such as depression, mania, psychosis and many more) predominantly with comorbid substance use disorders, may be a significant risk factor for risk behavior in various HIV-AIDS patients[15].The association between other factors including coping mechanism, tendencies for depression, quality of life, anxiety, and distress was also evident in several researches among patients with HIV-AIDS [16-18].

The current study focuses on measuring the self-esteem, psychiatric disturbances and QOL of PLWHA . The research will emphasize the effects of demographic characteristics (gender, age and qualification) on QOL, self-esteem and psychiatric symptomatology. Such data are required to help plan awareness and intervention programs against HIV.

SUBJECTS AND METHODS

Participants

114 patients dependent on drugs, already diagnosed with HIV/AIDS were selected through non-probability consecutive sampling technique from the inpatient facility of model drug abuse and treatment center of Department of Psychiatry & Behavioral Sciences, DHQ Hospital, Faisalabad Pakistan.

Instruments

Informed consent form was devised by researchers. Demographic sheet was used to record demographic variables. Further data were collected, on following scales.

Rosenberg Self-Esteem Scale

This is a 10-item scale developed by Rosenberg[19], it has a 4-point Likert type ranged from 0 (strongly disagree) to 3 (strongly agree). Item numbers 2, 5, 6, 8 and 9 were scored in reverse. Scores between 15 to 25 indicate normal self-esteem; however a score of less than 15 suggests low self-esteem while score more than 25 hints high self esteem.

WHO QOL-BREF

To measure the quality of life among sample, self-administered tool, WHO QOL-BREF[20] was used. The scale has 26 items and assesses quality of life in four domains i.e. psychological health, environment, physical health and social relationship. WHO QOL-BREF has 5-point Likert type scale, diverse response measures are used across the different domains.

Self-Report Questionnaire

Self-Report Questionnaire[21] consists of 24 items. The first 20 items are aimed to identify non-psychotic disorders, and the remaining four tend to screen psychotic disturbance. A score of 7 was set as cut off score.

Procedure

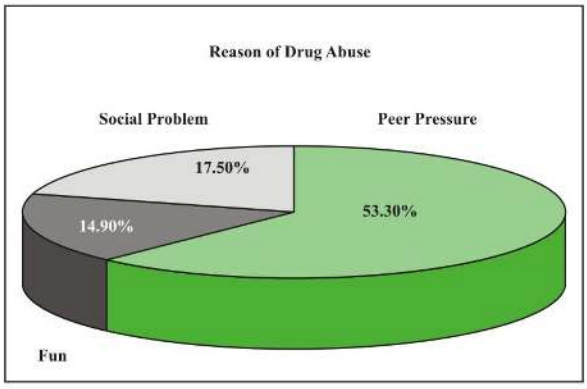
After the approval of research proposal from Ethical Review Committee of Faisalabad Medical University Faisalabad, Pakistan, Psychologists were selected and trained regarding administration of these tools on patients. Raw data were entered on SPSS 23 and analyzed through Pearson product moment correlation and single sample t-test.

RESULTS

Results showed that the patients' age ranged from 11 to 60 years (M=32.59, SD=7.79). Out of 114 patients, 113 were male, 52 (45.6 %) were unmarried, 67 (58.8%) patients belonged to lower middle class, 60 (52.6 %) lived in urban areas and 85(74%) patients had their own place to live. 39 (34.2%) patients were unemployed, whereas 25 (21.9 %) were skilled laborers (see table 1). Further data showed that about half of the patients (53%) started drug use under peer pressure (figure 1).

Results depict that majority of the HIV positive drug dependents (82.5%) scored below normal range on the scale of Self-Esteem indicating low self-esteem and 94.7% HIV positive drug dependents scored above cut off on the Self-Report Questionnaire showing high rates of psychiatric disturbances. The results were confirmed by one sample t-test (see table 2).

Figure 1



Mean of quality of life (QOL) of HIV positive drug dependents on physical health domain was16.02 with SD of 3.92, psychological

Table 1
Demographic Details of the Sample

Variables		Frequency	Percentages
Gender	Male	113	99.1
	Female	1	.9
Age Group	11-20	5	4.4
	21-25	21	18.4
	26-30	29	25.4
	31-35	25	21.9
	36-40	15	13.2
	41-45	10	8.8
	46-50	6	5.3
	51-55	3	2.6
Marital Status	Single	52	45.6
	Married	56	49.1
	Divorced	5	4.4
	Separated	1	.9
Residential Area	Urban	60	52.6
	Rural	54	47.4
Educational Status	Illiterate	20	17.5
	Primary	29	25.4
	Middle	40	35.1
	Metric	12	10.5
	Intermediate	8	7.0
	Graduate	1	.9
	Professional	4	3.5
Profession	Unemployed	39	34.2
	Unskilled	11	9.6
	Skilled	25	21.9
	Shopkeeper	13	11.4
	Farmer	12	10.5
	Student	1	.9
	Business	4	3.5
	Others	9	7.9
Socioeconomic Status	Lower	36	31.6
	Lower Middle	67	58.8
	Upper Middle	11	9.6

Table 2
One-sample t-test on Self-Esteem and Self Reporting Questionnaire Scores

Variables	M	SD	n	Comparison Value	95% CI for Mean Difference	t
Self-Esteem Scale	11.25	4.32	114	-2.75	-3.55,-1.94	-6.788***
Self-Report Questionnaire	14.45	4.37	114	7.45	6.64,8.26	18.21***

Note. Test Value for Rosenberg Self-Esteem Scale was 14 and Test Value for Self-Report Questionnaire was 7.

health domain of QOL had a mean of 17.58 with SD of 4.13, social relationship domain of QOL had a mean of 8.72 with SD of 2.89 and environment domain of QOL had a mean of 22.75 with SD of 5.52 (see table 3). Pearson product moment correlation analyses showed that there was significant positive relationship between all four domains of quality of life i.e. physical, psychological, social and environmental. Self-report questionnaire was found to be significantly negatively associated with only one domain of quality of life i.e. physical health. However no significant relationship was found between self-esteem and quality of life (see table 4).

Table 3
Mean and Standard Deviation of four components of WHO QOL-BREF Scale

Components of WHO QOL-BREF Scale	N	Minimum	Maximum	Mean	Std. Deviation
Physical Health	114	8.00	26.00	16.02	3.92
Psychological health	114	7.00	28.00	17.58	4.13
Social Relationship	113	3.00	15.00	8.72	2.89
Environment	114	10.00	38.00	22.75	5.52
Valid N (listwise)	113				

Table 4
Correlation Matrix for all the Variables Used in the Study (N = 114)

Variables	1	2	3	4	5	6
1	--	-.08	-.11	-.08	-.03	-.05
2	--	--	-.15**	.03	-.04	-.10
3	--	--	--	.45**	.47**	.56**
4	--	--	--	--	.37**	.55**
5	--	--	--	--	--	.50**

*Note. 1 = Self esteem; 2 = Self reported scale; 3 = Physical Scale; 4=Psychological, 5=Social,6=Environmental *p < .05. **p < .01. ***p < .001*

Table 5
Multivariate Analysis of Variance of Demographic Variables on Quality Of Life

Source	Dependent Variable	S.S	df	M.S	F	P
Age Group	Physical Health	58.138	7	8.305	.662	.702
	Psychological Health	115.880	7	16.554	1.635	.164
	Social Relationship	49.154	7	7.022	.756	.628
	Environment	224.790	7	32.113	1.521	.198
Resident	Physical Health	54.79	1	54.79	4.37	.045*
	Psychological Health	121.73	1	121.73	12.03	.002**
	Social Relationship	41.34	1	41.34	4.45	.043*
	Environment	49.397	1	49.397	2.339	.137
Marital Status	Physical Health	14.793	3	4.931	.393	.759
	Psychological Health	26.249	3	8.750	.864	.470
	Social Relationship	9.667	3	3.222	.347	.792
	Environment	53.246	3	17.749	.841	.482
Profession	Physical Health	39.420	7	5.631	.449	.863
	Psychological Health	159.698	7	22.814	2.254	.057
	Social Relationship	40.663	7	5.809	.625	.731

Table 6
Mean of Urban and Rural Areas in Relation to Four Domains of Quality of Life

		Domains of Quality of Life			
		Physical Health	Psychological Health	Social Relationship	Environment
Resident	Urban	15.6	17.9	8.48	22.5
	Rural	17.9	19.9	8.98	22.8

Multivariate analysis of variance (MANOVA) has showed significant statistical difference on three domains of quality of life i.e. physical health, psychological health and social relationship, as per type of

resident (see table 5). HIV positive drug dependents living in rural areas had significantly better quality of life on physical health, psychological health and social relationship domains (see table 6). However MANOVA has failed to establish enough evidence to establish the effect of age group, marital status and profession on quality of life of HIV positive drug dependents (see table 5).

DISCUSSION

Results of the current study 114 HIV positive dug dependents were admitted in the model drug abuse and treatment center during the period of study. Demographic analysis showed that majority of these patients were males, in their early adulthood, married, had none or low education and belonged to lower middle class which is consistent with the literature that asserts that male gender in their young age, unemployed and with low education are associated with alcohol and drug dependence[22]. There are multiple reasons that can hook a person on drugs, such as illiteracy, unemployment, low education, poor coping strategies, interpersonal issues and so on; amongst these peer influence is considered as one of the strongest elements of adolescent substance use. A generally held view is that social pressure from friends to use drugs and alcohol is a major contributor to substance use[23] which was also proved by the results of current study along with other factors such as social problems and fun seeking.

Quality of life (QOL) among PLWHA is a major issue. People living with HIV and AIDS (PLWHA) experience considerable decline in health-related quality of life throughout the course of the ailment. The quality of life for PLWHA is compressed physically, mentally, socially and environmentally on all the four domains recognized by the World Health Organization[24]. The findings of the current research showed that patients with HIV/AIDS exhibited low self-esteem and poor quality of life. These findings are in line with other researches which asserted that physical attributes such as pain, low energy because of recurrent fatigue, inability to do daily activities and failure to sleep or maintain sleep had great influence on physical health and overall QOL[25]. Similarly factors such as cognition, body image and negative feelings about self and self-esteem had huge impact on the psychological well-being of PLWHA and this further had effect on their quality of life[26,27]. The social interactions of PLWHA are effected by the level of acceptance in the home and community along with social support, personal relations with family/ friends and sexual relations[28]. Environmental factors for instance safety and security, finance, home environment and social care also affects the QOL of PLWHA[29]. Another factor identified in current study is that people living in rural areas seem to have better quality of life in terms of physical health, psychological health and social relationship, this finding is also consistent with previous researches asserting that sociodemographic characteristics such as male gender, younger age, low socioeconomic status, residence area and unemployment significantly influence QOL[21].

An individual's well-being is not only influenced by his or her health status and response to treatment but also by psychosocial and environmental factors. Hence, the identification of factors that mark QOL is very significant. This helps in developing better healthcare and social services to PLWHA to enhance their functioning and overall well-being. Likewise, the identification of adjustable factors influencing QOL could help with the recognition of people with special needs to improve their QOL[30]. It has been recognized that patients with a good QOL at the beginning of treatment have healthier prognosis than those with a poor QOL[31].

In addition to showing high rate of psychiatric symptomatology, meaning there is a high possibility that sooner or later patients may develop psychiatric disorder; results also revealed these psychiatric disturbances seem to be associated with physical health domain of QOL of HIV positive drug dependents which in turn can intensify the psychiatric symptoms and affect the overall quality of life. Previous researches emphasized that PLWHA along with substance abuse are at the high verge of developing psychiatric disorders such as depression, anxiety, panic attacks, dysthymia and much more which directly or indirectly have adverse effect on their quality of life[22,23].

Thus psychiatric and substance abuse disorder among PLWHA may damage the quality of life, adversely affect the use of health services, influence health consequences and compromise adherence with complex medication regiments[22].

CONCLUSION

Results have exposed alarming rate of HIV prevalence among young males, who are married and have low education. Subsequently findings suggest that HIV positive drug dependents had low self-esteem, overall poor quality of life and vulnerability towards developing psychiatric disorders, hence the current research emphasizes the need for psychiatric attention for such patients. HIV positive drug dependents are already suffering and the stigma associated with it worsens the condition; it not only affects overall quality of life of patients and reduces the effect of treatment being provided. So there is a dire need to provide psychiatric attention to such patients and future researches should investigate the mechanism of development and maintenance of mental health issues among HIV positive drug dependents so that effective awareness and intervention programs can be employed and experimentally tested to reduce the chances of developing AIDS, associated mental disorders and enhance quality of life.

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