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HOPE FOR LIFE AND DEPRESSION: PEOPLE LIVING WITH HIV/AIDS

Esperança de vida e depressão: pessoas vivendo com HIV/Aids

Esperanza de vida y depresión: personas viviendo con VIH/Sida

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ABSTRACT

Objective: to analyze life expectancy and depression in people living with HIV / AIDS. **Method:** this is a descriptive, quantitative study of 17 people with HIV / AIDS who receive care at a Reference Hospital for Infectious Diseases in the city of João Pessoa / PB, Brazil. A Life Expectancy Scale and the HAM-D Depression Scale were used for data collection. **Results:** regarding the type of exposure that led to the diagnosis of HIV / AIDS, 88.2% (15) revealed unprotected sex, the single most prevalent civil status was the unmarried 58.8% (10). Life expectancy data presented a mean score of 38.47 ± 7.45, median 39, maximum 48 and minimum 27. **Conclusion**: faith and hope have important values, contributing to the capacity to deal with difficult situations and to maintain the quality of life, facilitating the psychosocial consequences of this condition.
Descriptors: HIV; Depression; Life expectancy.

RESUMEN

Objetivo: analizar la esperanza de vida y la depresión en las personas que viven con el VIH / SIDA. **Método:** se trata de una investigación descriptiva, cuantitativa realizada con 17 personas con VIH / SIDA que reciben atención en un Hospital de Referencia para Enfermedades Infectocontagiosas en el municipio de João Pessoa / PB, Brasil. Para la recolección de datos se utilizó una Escala de Esperanza de Vida y la Escala de Depresión HAM-D. **Resultados:** en cuanto al tipo de exposición que llevó al diagnóstico de VIH / SIDA el 88,2% (15) reveló el sexo desprotegido, el estado civil de mayor prevalencia fue el 58,8% (10). Los datos referentes a la esperanza de vida presentaron escore promedio 38,47 ± 7,45, mediana 39, máximo 48 y mínimo 27. **Conclusión**: la fe y la esperanza tienen importantes valores, contribuyendo en la capacidad de lidiar con situaciones difíciles y en el mantenimiento de la situación calidad de vida, siendo facilitadoras de las consecuencias psicosociales acorraladas por esa condición.
Descriptores: VIH; Depresión; Esperanza de vida.

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RESUMÉN

Objetivo: analizar la esperanza de vida y la depresión en las personas que viven con el VIH / SIDA. **Método:** se trata de una investigación descriptiva, cuantitativa realizada con 17 personas con VIH / SIDA que reciben atención en un Hospital de Referencia para Enfermedades Infectocontagiosas en el municipio de João Pessoa / PB, Brasil. Para la recolección de datos se utilizó una Escala de Esperanza de Vida y la Escala de Depresión HAM-D. **Resultados:** en cuanto al tipo de exposición que llevó al diagnóstico de VIH / SIDA el 88,2% (15) reveló el sexo desprotegido, el estado civil de mayor prevalencia fue el 58,8% (10). Los datos referentes a la esperanza de vida presentaron escore promedio 38,47 ± 7,45, mediana 39, máximo 48 y mínimo 27. **Conclusión**: la fe y la esperanza tienen importantes valores, contribuyendo en la capacidad de lidiar con situaciones difíciles y en el mantenimiento de la situación calidad de vida, siendo facilitadoras de las consecuencias psicosociales acorraladas por esa condición.

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INTRODUCTION

The advancement of the Human Immunodeficiency Virus (HIV) infection remains challenging the various scientific, political and social segments, and the epidemic is multifaceted and difficult to control. The person bearing the virus is not necessarily considered an AIDS patient, and might live years in the asymptomatic stage.[1,2]

HIV infection can lead to Acquired Immunodeficiency Syndrome (AIDS), which is considered a chronic disease. Over the years there has been a significant drop in mortality rates, associated with an increase in survival of people living with human immunodeficiency virus and/or acquired immunodeficiency syndrome, although reliance on Antiretroviral Therapy (ART) and its effects physical and psychological limitations.[3]

HIV infection remains one of the biggest problems for global public health and has cost more than 35 million lives. By 2016, one million people worldwide died of complications from the infection. By the end of 2016, there were approximately 36.7 million people infected with HIV worldwide. In Brazil from 2007 to June 2016, 136,945 cases of HIV infection were reported by the *Sistema de Informações de Agravos de Notificação (SINAN)* [Information System of Notification Aggravations].[4,5]

Associated to the diagnosis of HIV/AIDS, there are positive and negative feelings about their future and health status. One of the feelings that can emerge in the face of diagnosis is hope, seen as a constitutive element of human existence in time, because it is the one that sustains the openness to the future of power/being, and it nourishes our capacity to dream and to walk.[6]

Keeping hope even when adversity comes along is about having something or someone to live for. Family unity, good relationship with friends, and faith are essential for strengthening hope in people's lives. Especially in people having chronic diseases, such as AIDS, the perpetuation of hope provides them with a better quality of life, despite the difficulties imposed by the disease and its treatment. In the practice of care in patients with HIV, it is common to observe the sense of hope shown during health follow-up.[7]

Neurocognitive disorders associated with HIV are a concern for those who care for these people as they reach 25% of those affected by the virus.[8]

A study conducted in two groups, one with people diagnosed with HIV and the other in the absence of a diagnosis, showed a statistically significant association between the group with HIV and depressive symptoms.[9]

Living with the diagnosis of HIV/AIDS, rejection, prejudgments and stigmas of society can lead the person to develop undesirable feelings, which lead to life quality depreciation and consequently to mental illness.[10]

The psychiatric disorder most frequently detected in people with HIV is depression, which is characterized by loss of interest and pleasure in everything, by the feeling of sadness and low self-esteem. It is an insidious disease that leads to the destruction of hope and also affects the lives of those around the patient.[11]

The risk factors for depression in HIV-infected persons are family history of depression, personality disorder, alcohol and drug use, unemployment, AIDS constitutional symptoms (such as weight loss, chronic diarrhea, seborrheic dermatitis and others), multiple losses, neglect, little support and social conflict, loneliness, mourning, therapeutic failure and advanced disease.[12]

A study of 107 seropositive individuals in Portugal demonstrated a prevalence of depressive symptoms of 65.5% in HIV-infected individuals.[13]

Numerous times, the psychological effects caused in these patients is not considered, since they do not constitute a symptom of the disorder itself.[14]

Bearing in mind this context, the following two simple measures should be adopted: the monitoring of depressive symptoms that favors the early diagnosis of depression and, consequently, its adequate treatment. These are of great relevance because they allow the detection and consequently the early treatment of depressive symptoms that may negatively influence the quality of life of seropositive individuals, while preventing the adoption of risk behaviors and failure to adhere to ART, improving the health of these patients by preventing the development of resistant strains of the virus and preventing the spread of HIV.[13]

Quality of life of people bearing HIV is more constrained, because in this situation, the individual changes his way of relating to the world, re-evaluating concepts, values and beliefs, reviewing postures, behaviors, and attitudes in the new context. These changes can raise feelings and uncertainties such as fear of death, uncertainty of the future, the stigma of disease and anxiety, generating intense suffering for the patient.[15]

During the assessment of the seropositive patients' life quality, the psychological domain deserves particular attention due to its influence on the well-being and balance of those patients.[12]

In this regard, the family members and health professionals involved in the treatment of the client are essential people in helping to cope with the disease, since they can understand the meanings they construct in relation to seropositivity and provide emotional support in coping with the disease. Trying to avoid to the maximum that these individuals acquire some mental disorder.[2]

Considering the aforementioned, it is essential to know about either the presence or absence of hope and depression in HIV/AIDS bearing people, since it can contribute to the care of the client, directing the activities of the multiprofessional team for the promotion and prevention of depression and hopelessness, aiming to guarantee improvements in the quality of life of this population.

This study aims to analyze both life expectancy and depression in HIV/AIDS bearing people.

METHODS

It is a descriptive study with a quantitative approach, which was performed at a referral Hospital for Infectious Diseases in *João Pessoa* city, *Paraíba* State, Brazil. The population comprised 20 people hospitalized with a diagnosis of HIV/AIDS, the sample of which was 17 people diagnosed with HIV/AIDS who receive care at the site of data collection. This sample was calculated using 95% confidence interval and 10% margin of error, through the program Statdisk U.S.A for Windows. Data collection took place over the period from September to October 2017.

The following inclusion criteria were considered: individuals diagnosed with HIV who receive assistance at the site of data collection, with cognitive and physical capacity preserved. Those who refused to participate in the study were excluded, presented speech difficulties and had no positive HIV diagnosis.

There was used a Life Expectancy Scale that has 12 items written affirmatively in which the items are graded by four-point Likert scale: strongly disagree (1), disagree (2), agree (3), and completely agree (4). Items 3 and 6 show inverted scores, in other words, strongly disagree (4), disagree (3), agree (2), completely agree (1). The total score varies from 12 to 48 and the higher the score, the higher the level of life expectancy. It is a scale considered brief (10 minutes to be completed) and easy to understand.[16]

The 24-item Hamilton Depression Rating Scale (HAM-D) was also applied, with scores between 7 and 17 defined as mildly depressed, between 18 and 24 moderately depressed, and scores above 25 severely depressed points.[17]

The data were processed in the Statistical Package for Social Sciences (SPSS) version 19.0, using absolute and relative frequency, mean and standard deviation of the mean. The t-test was applied to verify the statistical relation between the Life expectancy and Depression Scale means, being considered significant when $p<0.05$.

This research was approved by the Ethics Committee in Research from the *Centro Universitário de João Pessoa (UNIPÊ)* according to the *Certificado de Apresentação para Apreciação Ética (CAAE)* [Certificate of Presentation for Ethical Appreciation] No. 71135917.3.0000.5176. All participants received two copies of the Informed Consent Form (ICF), as recommended by the Resolution No. 196/1996 from the National Health Council.[18]

RESULTS AND DISCUSSION

The subjects were within an average age of 53.2±14.78 years old, 64.7% (11) men and 35.3% (6) women. Regarding the type of exposure that led to the diagnosis of HIV/AIDS, 88.2% (15) were related to unprotected sex and 11.8% (2) did not know how to report.

Concerning the schooling, 35.3% (6) reported incomplete elementary school, and being single was the highest prevalence with 58.8% (10), which was followed by 17.6% (3) divorced. The data referring to life expectancy presented a mean score of 38.47±7.45, median 39, maximum 48 and minimum 27. More information is shown in **Table 1**.

Table 1 - Life expectancy to people living with HIV/AIDS, *João Pessoa city, Paraíba* State, Brazil, n=17.

	Strongly disagree		Disagree		Agree		Completely agree	
Item	N	%	N	%	N	%	N	%
1. I am optimistic about life.	-	-	3	17.6	6	3.3	8	47.1
2. I have short- and long-term plans.	1	5.9	4	23.5	5	29.4	7	41.2
3. I feel so alone.	7	41.2	3	17.6	5	29.4	2	11.8
4. I can see possibilities amid the difficulties.	-	-	3	17.6	6	35.3	8	47.1
5. I have a faith that comforts me.	-	-	-	-	4	23.5	13	76.5
6. I am afraid of my future.	9	52.9	5	29.4	3	17.6	-	-
7. I can remember happy and cheerful times.	-	-	2	11.8	10	58.8	5	29.4
8. I feel very strong.	-	-	2	11.8	7	41.2	8	47,1
9. I feel capable of giving and receiving affection/love.	-	-	4	23.5	7	41.2	6	35.3
10. I know where I want to go.	-	-	5	29.5	6	35.3	6	35.3
11. I believe in the value of each day.	-	-	2	11.8	10	58.8	5	29.5
12. I feel that my life has value and utility.	2	11.8	2	11.8	8	47.1	5	29.5

Considering the depression, Table 2 shows the classification and score of the subjects under study.

Table 2 - Depression in people living with HIV/AIDS, João Pessoa city, Paraíba State, Brazil, n=17.

Depression classification	N	%
Absence	8	47.1
Mild	5	29.4
Moderate	4	23.5
Severe	-	-
Total score		
Average	9.6	
Standard deviation	7.18	
Median	7	

The higher prevalence of men confirms the epidemiological data, in which this gender is more representative in the HIV/AIDS scenario.[5]

In regards to unprotected sex, this variable was also identified in another study as the main form of HIV/AIDS infection. Nevertheless, it is important to note that this pathology can occur through other forms such as: sharing of syringes and shavers, blood transfusion, from mother to child during pregnancy.[19]

A study carried out with 111 HIV-positive women in the *Ceará* State (2012) found that the item ("I have a faith that comforts me") was the one that obtained the highest hope score, corroborating with the finding of this research where 76.5% of the study subjects said they have a faith that comforts them.[7]

This result demonstrates the strengthening of the process of adaptation and coping with the disease due to hope, religiosity, spirituality and personal beliefs, which can provide a better understanding of the painful events.[7]

Two other relevant scores in which they obtained a low score (**Table 1**), in other words, in that item the majority of the subjects of the research disagreed with the affirmative, was item 3 ("I feel so alone") and item 6 ("I am afraid of my future"). In *São Paulo* city, a study of 200 women with HIV/AIDS corroborates this research, where it was noticed that most women disagreed when asked about item 3 and item 6, but there was no total disagreement, as well as in this research.[20]

In the aspect of feeling alone as evidenced by the agreement of 29.4% of those surveyed, it can be explained by the consequences of HIV/AIDS infection, which may lead to fragility, neurocognitive decline, renal dysfunction, cardiovascular diseases, metabolic alterations.[21]

A study performed in *São Paulo* (Brazil) showed the effectiveness of the Herth Hope Scale in identifying high levels of hope, also relating faith as comfort, discussing and distinguishing the concepts of spirituality and religiosity in women bearing HIV/AIDS.[20]

Depression is directly related to HIV diagnosis according to a study of 325 outpatients in Uganda.[22]

The diagnosis of HIV/AIDS infection has a great repercussion in the life of the individual, triggering psychological, physiological and even social changes. It brings changes in lifestyle, and there are also doubts and even fear about the future. The individual is often impacted to adapt to rigid antiretroviral therapy schedules.[23]

As a result of so many changes, mental health problems may arise, such as depression, which leads the individual to seek religious as well as professional support, in order to cope with the disease.[24]

It is estimated that by the year 2030, depression will be one of the three leading causes of illness worldwide, along with HIV/AIDS and ischemic heart disease, studies in high- and low-income countries show that there is an association between HIV/AIDS and depression, and report that depression affects the quality of individuals living with HIV/AIDS and is one of the main causes of suicide.[25]

Self-help groups can provide individuals with HIV/AIDS with emotional support to better cope with the disease, enabling a better quality of life and better adherence to treatment.[26]

A study conducted in (2017) through database research has shown that group therapy aims to improve the well-being of individuals through psychological therapy through a group containing other individuals with HIV/AIDS, encourage these people. In group therapy often happens training in techniques, such as relaxation and coping skills, and education about the disease. These group-based psychosocial interventions may have an effect on depression measures, but the clinical importance of this is unclear. More specific studies are needed to assess whether group therapy actually contributes to the psychological well-being of adults with HIV/AIDS.[27]

It is estimated that there are more than 33.3 million people living with HIV/AIDS worldwide, but as a result of health-related efforts around the world, there has been a reduction in the number of cases of HIV infection, as well as deaths, and the number of individuals who have access to antiretroviral treatment has increased significantly.[28]

The present study demonstrated that 52.9% of respondents presented mild or moderate depression, characterizing the high incidence of depression in individuals living with HIV/AIDS. According to a study done in the *Rio Grande do Sul* State, the HIV/AIDS epidemic is one of the major challenges for global health.[29]

A study of patients diagnosed with HIV/AIDS in the city of Cardum, Sudan's capital, between 2015 and 2016, identified that depression is prevalent in these individuals, has shown that HIV/AIDS can affect the individual's neurological system and so lead to depression, where this serious disorder may hinder adherence to HIV/AIDS treatment, thereby increasing the progression of infection. It was observed that 63.1% of the interviewees presented depression, where 19.3% presented mild depression, 32.4% moderate depression and 11.4% severe depression.[30] Herein, the prevalence of depression was 52.9%, where 29.4% presented mild depression and 23.5% presented moderate depression.

Correlating the life expectancy score with the depression score obtained $p \leq 0.05$, revealing statistical significance between the two variables.

This correlation might indicate that people bearing HIV/AIDS are affected by feelings that can trigger life expectancy, directly increasing the possibility of cases of depression.

CONCLUSIONS

This study meant to assess both life expectancy and depression in HIV/AIDS bearing people. There has been found a predominance of mild to moderate depression, and also a positive score for life expectancy.

Considering the aforesaid, it is relevant to develop therapeutic interventions and psychosocial support, aiming to prevent depressive episodes, considering their impact on the evolution of the disease and consequences on the life quality of people living with HIV/AIDS.

Through this study, faith and hope have important values, contributing to the capacity to deal with difficult situations and to maintain the quality of life, facilitating the psychosocial consequences of this condition.

Therefore, it is necessary to know the socio-cultural context to which people living with HIV/AIDS are inserted, the team must establish a bond of trust, where the consultations should be explored as much as possible, under the prism of being welcomed, thus reporting, their experiences, doubts, and aspirations.

Hence, it is required, and it is hoped, with this study that health professionals understand how essential it is to address the health of the HIV-positive in a broader appraoch.

Nursing should consider and develop proposals for a more detailed anamnesis, involving psychosocial aspects, besides the physicists already addressed.

These results can contribute to the reformulation of health actions by the management, and especially by nurses who play a central role in health care, health promotion and disease prevention, supporting as scientific evidence, thus contributing to the consolidation of nursing as a science.

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