PSYCHOLOGICAL AND SOCIAL ASPECTS OF AIDS

by M. Basheer Ahmed, M.D.

Acquired Immune Deficiency Syndrome (AIDS) is one of the most serious epidemics of modern times. One and a half million individuals are suspected of carrying the virus; and AIDS will be one of the ten leading causes of death in this country. This illness causes a severe psychological impact not only on the victim, but, on relatives and others close to the victim and the community at large.

The major form of psychological distress in AIDS patients is preoccupation with rapidly declining course of death. The usual response when one hears about disease is disbelief, shock and denial. This is usually followed by anger, acute anxiety and depression. Loss of self-esteem, guilt and exacerbation of feeling of alienation and isolation from both peer group and society are not uncommon. More severe depressive symptoms are also observed which consist of anorexia, insomnia, hopelessness, helplessness and suicidal feelings. Anxiety symptoms consist of agitation, tachycardia and panic attacks. Anger directed towards illness, medical care, discrimination and public response to the disease is often intense.

The psychological and social stresses lead to acting out behavior in certain individuals and may result in excessive indulgence in drinking, drugs and sometimes in indiscriminate sexual behavior. As the disease progresses the individual continues to experience distress, disruption of normal functioning, estrangement from families, community and social rejection. Stigmatization, loss of job, income, and even home, may further aggravate this situation. During the last stage of illness, patient backs off and shows willingness to face the reality, develop a new sense of self and accept altered form of relationship with family and friends. At this stage the individual may continue to struggle to remain engaged with others emotionally, or may give up fighting and accept this fatality.

Monitoring of mental status and cognitive deficit should become an integral part of the overall management of AIDS patients. Depressive symptoms and suicidal risk should be assessed throughout the course of illness. There is no one proven way to help these psychologically distressed patients. Supportive individual and group psychotherapy and offering empathy in a non-judgmental way lowers the level of distress. Intervention during the early stage of illness is necessary so that the individual may regain some sense of control over his life. In addition, psychological counseling and financial and legal assistance are also needed to support the individual going through crisis. The final stage of adjustment is spent primarily in preparing for death.

Anger of AIDS victim is often directed at the practioner who can not offer hope but prescribes experimental drugs with limited benefit and multiple side effects. It is recommended that physicians confront their own attitude about homosexuality and possible homophobic attitudes, before treating people with AIDS. They should refer such patients to other physicians if they cannot interact with understanding. Fear of disclosure and social condemnation is a major hinderance for people at risk to explain fully their sexual and life style patterns to physicians. AIDS has become a sensitive issue and physicians must exert caution in what they say and how they approach the problem.

The intense media coverage of AIDS has increased public awareness and public response. AIDS hysteria has developed nationally in spite of massive public education. Although casual contact has not been shown to transmit AIDS, widespread discriminatory behavior is noticable in all segments of society. Many health professionals started protecting themselves in inappropriate manner. The word quarantine has been echoed by health professionals and lay public. Some medical facilities have barred physicians who have AIDS, themselves, from treating AIDS patients. The public continues to show disbelief in data regarding transmission of AIDS and demands absolute and one hundred

percent proof. They act and react with fear and anger, and ignore reason. The generalized AIDS phobia has been manifested by various examples. Prison guards refuse to take prisoners with AIDS to court, and insist on establishing separate facilities for homosexual inmates. Judges have refused to have AIDS victims in their courtroom; undertakers have refused to handle bodies of AIDS patients. Many landlords and employees are discriminating against not only AIDS patients, but, members of high-risk groups. Many parents refuse to send their children to school when a schoolmate is found to be suffering from AIDS infection. Most recently, Kubler-Ross was unable to develop a residential program for children with AIDS, in a community in Virginia, due to community's decline to issue a permit to build the home for these children.

Physicians still face enormous risk in dealing with this complex issue. Should one insist upon subjecting all individuals in high risk groups (homosexuals and bisexuals, I.V. drug users and individuals with multiple sex partners) to have HIV test? How do we guarantee confidentiality of patients who show positive results? How should we reassure health workers and public at large that their health and safety is not jeopardized by casual contact? Hospitals and other agencies lack legal directions for dealing with employees who have AIDS, or whose test is positive.

The only solution to this complex psychological-biological-social problem is prevention through public education. Health care professionals must receive current information regarding proper safety precautions and encouraging the rational confirmation of negative attitude, on an ongoing basis. All HIV antibody individuals must assume that they are infectious to sexual partners and must avoid indiscriminate sexual behavior and sharing of I.V. needles. The use of condoms can reduce, but not eliminate, the risk to sexual partners. It must be pointed out that seropositive pregnant females can transmit infection to fetus. Recently there has been a considerable increase in children who are born with AIDS infection. Some of these children may not develop full fledged AIDS until age eight or nine. However, they are showing retardation in physical, as well as emotional and intellectual, development.

While current knowledge is giving us fair insight into this complex problem, it is also raising many unsolved controversial problems. Providing clean needles to drug users may reduce the incidence of AIDS, but the drug users may take this gesture as a sign of approval of their behavior, which is equally dangerous to public health. Similarly, widespread propaganda on television, and in schools, about the use of condoms is also regarded as giving sanction to premarital sexual behavior.

These are serious social issues, and it is time that physicians take some lead in dealing with them. Prepare to educate the public at large, counsel with patients before HIV antibody tests and follow closely those who show the HIV antibody. Treat with understanding those who develop AIDS symptomatology. It must be pointed out here that we need to pay attention to close family members who are staying with the patient. They suffer not only the grief of caring for a dying patient, but also face rejection by other family members, friends and community at large. Supportive psychotherapy and family counseling should be an integral part of treatment planning.

At the risk of being repetitious, I cannot emphasize strongly enough the role we physicians must play in protecting the uninfected public through education. One way to start the educational process is by taking a serious interest in discussing with our own patients their sexual activity and drug use.

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