

Socio-Demographic Profiles of HIV-Infected Persons Using Dysfunctional Coping

O.H. Ezeh^{1*} and C.C. Ezeh²

¹Department of Community Medicine, Ahmadu Bello University, Zaria, Nigeria.

²College of Agriculture, Ahmadu Bello University, Zaria, Nigeria.

*Correspondence:

Ezeh O.H, Ahmadu Bello University, Zaria, Nigeria.

Received: 19 July 2019; Accepted: 14 August 2019

Citation: Ezeh O.H, Ezeh C.C. Socio-Demographic Profiles of HIV-Infected Persons Using Dysfunctional Coping. J Med - Clin Res & Rev. 2019; 3(4): 1- 6.

ABSTRACT

Background: Many HIV –infected persons experience psychological difficulties that may require psychological intervention. Socio-demographic characteristics may constitute risk factors for some physical and psychological difficulties. Identifying and targeting high risk subgroups for effective psychological screening and intervention may improve physical and psychological functioning/health and productivity.

Objectives: To identify HIV-infected persons coping by means of frequent use of dysfunctional coping strategies.

To assess the socio-demographic profiles of HIV-infected persons coping by means of frequent use of dysfunctional coping strategies.

Methods: This cross-sectional descriptive study was conducted, by administering 28-item Brief-COPE questionnaire, and socio-demographic questionnaire on 110 HIV-patients receiving HAART services at Ahmadu Bello University Teaching (A B UTH) Zaria, Nigeria, who were selected by convenience sampling technique.

Results: Results indicate that there was significant association ($P < 0.001$) between socio-demographics and dysfunctional coping; HIV-infected persons who coped by means of frequent use of dysfunctional coping were characterized by; older age (36-46), female gender (sex), Christian religion, 'others' (mixture of 3 minority tribes in Nigeria), married marital status, HIV-infection duration of 2-4years (shorter HIV-duration), and lower educational status.

Discussion: The socio-demographic differences reported may be due to differences in experiences and differences in subjective symptom reporting, etc.

Conclusion/Recommendation: There is need for targeted psychological and behavioral intervention for people living with HIV and demographic groups at high risks for dysfunctional coping, to enhance their coping skills.

Keywords

Socio-demographics, Dysfunctional Coping, HIV-infected persons.

Introduction

More than 36.9 million people worldwide were living with HIV/AIDS in 2017 [1], and in Nigeria 3.1 million people. However, the recently published Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) [2] reports 1.4 percent prevalence of the infection in Nigeria. These statistics may be attributed to high rates of stigma

and non-access of HAART and support services, and therefore non achievement of viral suppression in HIV patients. HIV/AIDS remains a global public health challenge [3]. HIV/AIDS is not just a physical health problem but also psychological, emotional, spiritual, social and cultural problem. Coping is volitional management of stressful events or conditions and regulation of cognitive, emotional, behavioral and physiological responses to stress [4]. It is the ability to generate and maintain psychological well-being despite living with a serious condition [5]. Coping strategies are psychological patterns that individuals use to manage

thoughts, feelings, and actions encountered during various stages of ill health and treatments Olle, and John, [6]. Dysfunctional coping is those styles of coping that employ avoidance, denial, self-blame, or detrimental ways of coping such as alcohol or drug abuse [7].

A study [3] showed that more than 40 percent of persons living with HIV-infection had poor coping skills and therefore required psychological intervention. Many more had psychological distress because, HIV-infection actually increases total stress loads of persons living with the infection. Study also showed that psychological distress and dysfunctional coping were strongly correlated in HIV-infected persons [3]. Side effects of HIV medication may also drive both psychological distress and dysfunctional coping in the form of substance use issue. The real impact of dysfunctional coping on HIV-patients is underestimated. Yet coping skills can be improved through psychological and behavioral intervention e.g cognitive behavioral therapy.

Reducing levels of dysfunctional coping will benefit HIV patients, reduce transmission and spread rates and increase rates of viral suppression.

Descriptive data are useful to identify those distressed and those at risk for coping dysfunction; their age, sex/gender, marital status, educational background, religious affiliation, their ethnic and social characteristics, lifestyles, family membership, recent life events, duration of their HIV-infection/ survivability, etc.

Describing their socio-demographic characteristics would help design disease control programs, identify potential target groups for interventions to change behavior in order to improve health outcomes, their needs, and therefore identify those with unmet psychosocial needs [8].

HIV-infection contributes to overwhelming physical, psychological and social problems. Clinical depression and suicidal tendencies are the most common psychological problems associated with living with HIV-infection. There are many research reports on different aspects of HIV disease, but little data if any are available on demographic predictors of dysfunctional coping in persons living with the virus. Therefore, it is important to identify demographic groups with high risks of dysfunctional coping among HIV patients, so that integrated intervention which includes; prevention, treatment and health promotion, can be planned and implemented.

Research Questions

Can socio-demographic factors place individuals/ persons living with HIV-infection at increased risks for dysfunctional coping?

What is the socio-demographic predictors of dysfunctional coping in a population of HIV-infected persons?

Objectives

- 1) To identify HIV-infected persons coping by means of frequent use of dysfunctional coping strategies.
- 2) To assess the socio-demographics of HIV-infected persons

coping by means of frequent use of dysfunctional coping strategies.

The general aim was to study socio-demographic risk factors associated with dysfunctional coping in HIV-infected persons. The information may help in planning preventive care and support. There has been little if any description of socio-demographic characteristics of HIV patients who cope with HIV-related stress by means of frequent use of dysfunctional coping strategies. Descriptive data are good primarily for identifying those at high risks for particular problems. Socio-demographic characteristics may constitute risk factors for certain physical and psychological morbidities. Diagnosis of chronic illness may raise challenges to psychological and emotional health.

Methods

The study, a cross-sectional descriptive research, was conducted using HIV patients accessing HAART services at Ahmadu Bello University Teaching Hospital (A B U T H) Zaria, Nigeria. The participants were 110 in number, 35 males and 75 females, mean age was 39.8 years, standard deviation 11.6, the age range was 18-75 years. Subjects were selected using convenience sampling technique. Only those participants readily available and were willing to participate actively in the study were recruited for the study. Ethical clearance was obtained from the ethical committee of the hospital. Consent to voluntarily participate in the study was also obtained from the participants.

To assess dysfunctional coping in HIV-infected persons, the 28-item Brief-COPE questionnaire was distributed to the subjects with about 85 percent response rate. Brief-COPE was highly reliable and valid instrument for measuring both functional and dysfunctional coping [9]. It has a good internal reliability, and factor structure which is consistent with the COPE inventory. The 28-item Brief COPE is answered on a 4-point scale ranging from "I don't do this at all" to "I do this a lot" Participants were asked what they usually do when they experience a stressful event. Although the whole 28-item questionnaire was administered, only the scores from the four dysfunctional subscales; Denial [DN], Behavioral Disengagement [BD], Substance Use [SU] and Self-Blame [SB]) were used for statistical analyses. A socio-demographic questionnaire was also administered to assess participants' socio-demographic characteristics. The results obtained on subscales of dysfunctional coping were taken into account separately and in combination of the 4 dysfunctional subscales (integrated/overall dysfunctional coping) used in this study for data analyses. The 4 subscales include;

1) Denial (D N)

Avoidance of the problem, refusal to believe that there is problem. Activities that aid denial include, drinking, sleeping, isolation etc.

2) Behavioral Disengagement (B D).

This involves giving up the attempt to deal with a situation.

3) Substance Use (S U)

This means frequent use of alcohol or other substances to cope with stress.

4) Self-Blame (S B)

Internalizing the problem and blaming oneself, beyond just taking

responsibility for one's actions, which may lead to low self-esteem, or even depression etc.

The descriptive data analysis includes calculations of frequencies, means and standard deviations (SD). Chi-square analysis was conducted for statistical differences. Regression analysis was also conducted for the age variable and the four major components of dysfunctional coping used in this study. For all analyses $p < 0.05$ was used to define the statistical significance. Data were processed and analyzed, using STATA software version 13.1.

Results

The sample comprised of 35 (31.82 percent) male and 75 (68.18 percent) female HIV patients, a total of 110 participants. More than one third 48 (43.64 percent) of the patients were married, while the demographic groups with about one third of the HIV patients each were 2-4 years, 38 (34.55) and 5-10 years, 38 (34.55 percent) HIV-infection duration.

Socio-Demographic Characteristics		Frequency	Percent
Age (years)	15-25	15	13.4
	26-35	24	21.82
	36-45	42	38.18
	46-55	18	16.36
	56-65	11	10.00
Sex	Male	35	31.82
	Female	75	68.18
	TOTAL	110	
Religion	Islam	54	49.09
	Christianity	56	50.91
	TOTAL	110	
Ethnicity	Hausa	34	30.91
	Yoruba	23	20.91
	Igbo	15	13.64
	Others	38	34.55
	TOTAL	110	
Marital Status	Single	21	19.09
	Married	48	43.64
	Separated/Divorced	14	12.73
	Widowed	27	24.55
	TOTAL	110	
HIV-duration/ survivability (Years)	1 year & less	11	10.00
	2-4	38	34.55
	5-10	38	34.55
	More than 10 years	23	20.91
	TOTAL	110	
Educational Status	Primary (Non formal/formal)	44	40.00
	Secondary	36	33.70
	Tertiary	30	27.00
	TOTAL	110	

Table 1: Selected Socio-demographic characteristics of respondents.

Variable	Obs.	Mean	Std. Deviation	Min.	Max.
DN	110	5.75	1.89	2	8
BD	110	3.25	1.52	2	8
SU	110	2.54	1.16	1	8
SB	110	3.63	1.51	2	8
TOT (Integrated dysfunctional C	110	15.16	3.03	8	23

Table 2: Summarizing Dimensions of Dysfunctional Coping and Their Composite (Total)/Integrated Dysfunctional Coping.

Means and standard deviations for the variables studied are presented in Table 3 above.

Variable	Male	Female	Total Prevalence Rate	Percent N=110
DN	20	48	68	61.8 percent
BD	14	31	46	41.8 percent
SU	13	11	24	21.8 percent
SB	18	43	61	55.5 percent
Integrated/TOT (Whole)	17	32	49	44.5 percent
Integrated/TOT (Whole)	17	32	49	44.5 percent

Table 3: Differing Prevalent rates of Dimensions of Dysfunctional Coping and Their Composite (Total/overall).

Chi-square analyses for categorical variables were conducted in order to assess the strength of association between socio-demographic variables and levels of dysfunctional coping.

Socio-Demographic Characteristics		High (dysfunctional coping)	Low (dysfunctional coping)	Chi- squared P< Value
Age (years)	15-25	8	7	
	26-35	9	15	
	36-45	21	21	$X^2=101.64$
	46-55	7	11	$P < 0.001$
	56-65	4	7	
Sex	Male	17	18	$X^2=45.79$
	Female	32	43	$P < 0.001$
Religion	Islam	23	31	$X^2=27.03$
	Christianity	26	30	$P < 0.001$
Ethnicity	Hausa	14	20	$X^2=83.75$
	Yoruba	14	9	$P < 0.0001$
	Igbo	4	11	
	Other	17	21	
Marital Status	Single	14	7	
	Married	19	29	
	Divorced/ Separated	7	7	$X^2=73.11$
	Widowed	9	18	$P < 0.001$
HIV -Duration/ Survivability (Years)	1 year & less	4	7	
	2-4	21	17	$X^2=82.74$

HIV -Duration/ Survivability (Years)	5-10	16	22	P<0.001
	More than 10 years	8	15	
Educational Status	Primary (Non-Formal/ Formal)	22	27	X ² =38.87
	Secondary	15	20	P<0.001
	Tertiary	12	14	

Table 4: Association between Selected Socio-demographic Variables and levels of integrated Dysfunctional coping (TOT).

Source: Field Survey, 2018

There was significant association between socio-demographic characteristics and levels of dysfunctional coping among HIV-persons.

Frequent use of dysfunctional coping may add to the total cumulative stress loads of persons living with HIV infection, worsen health-seeking behavior, adherence to treatment plans and increase the use of substance. Effective, functional and healthy coping is a predictor of quality of life.

Age	Coefficient	Std. Err.	t	P>
DN	2.08	0.54	3.84	0.001
BD	2.75	0.90	2.99	0.003
SU	2.54	1.19	2.13	0.036
SB	2.88	0.95	3.03	0.003

Table 5: Regression of Age against DN, BD, SU and SB. R-squared=0.87.

Table 5 indicates that age of the participants influenced the 4 major components of dysfunctional coping Denial coping (P<0.001), Behavioral Disengagement coping (P<0.003), Substance Use coping (P<0.036) and Self-Blame coping (P<0.003) investigated. As age increased, the components of dysfunctional coping increased.

Key Findings

Data analyses suggest that:

- The overall prevalence of dysfunctional coping was high 49(44.5 percent).
- There was a significant association between socio-demographics of the participants and overall dysfunctional coping (P<0.001).
- HIV-patients coped with the stressors associated with living with HIV-infection by means of frequent use of dysfunctional coping, depending on their; age, sex/gender, marital status, duration of HIV-infection, religion, ethnicity, and educational status
- Age of the participants influenced the 4 major components of dysfunctional coping Denial coping (P<0.001), Behavioral Disengagement coping (P<0.003), Substance Use coping (P<0.036) and Self-Blame coping (P<0.003) investigated. As age increased, the components of dysfunctional coping increased.
- The study only found a link between socio-demographics

and dysfunctional coping, it did not show that one caused the other.

- Socio-demographic factors associated with dysfunctional coping include; older age (36-46), female gender (sex), Christian religion, “other” **tribe, married marital status, HIV-infection duration of 2-4years (shorter HIV-duration), and lower educational status.

** means mixture of minority tribes (Tivs, Bijjus, Birons) outside the 3 major tribes (Hausas, Yorubas and Igbos) in Nigeria.

Discussion

Overall, the findings of the present study indicate that prevalence of dysfunctional coping was high among HIV-patients. And there were socio-demographic differences in levels of dysfunctional coping. These findings are consistent with previous studies. Dysfunctional coping may provide temporary relief but in the long run the relief would not last, and may even lead to states of depression or other psychological morbidities. For example, Dumont and provost [10] reported that men and women with low self-esteem were more inclined to use dysfunctional coping measures to deal with stress eg, illegal and antisocial activities. These differences may be attributed to different factors [9]. Although socio-demographic factors are generally non-modifiable risk factors that may not readily change, they can be effectively managed and controlled.

Other factors that may work to promote dysfunctional coping in HIV-patients include; pessimistic thinking, that is tendencies to anticipate negative outcomes. Successful and functional coping may be facilitated by optimistic thinking-tendencies to anticipate positive outcomes, which can also serve some protective functions.

Additional factors that may serve as risk factors for dysfunctional coping include; poor psychological functioning, current substance abuse, premorbid personality, etc.

Conclusion

The study has been able to demonstrate that there was an association between socio-demographic characteristics and dysfunctional coping in a population of HIV-infected persons. It only found a link between socio-demographics and dysfunctional coping. It did not show that one caused the other.

Recommendation

Behavioral and psychological intervention may help to improve health and behavioral effects associated with poor psychological function.

References

1. <http://www.hiv.gov>>pepfar-global-aids
2. NAIIS. HIV/AIDS in Nigeria: New Survey Report. 2018.
3. Ezeh OH, Ezeh CC. Correlates and Predictors of Psychological Morbidity in HIV-Infected Persons A Cross-sectional Study, Open Journal of Medical Psychology. 2019; 8.

-
4. Lazarus RS, Folkman S. Stress Appraisal and Coping. New York: Springer. 1984.
 5. Folkman S. Positive psychological states and coping with severe stress. *Social Science and Medicine*. 1997; 45: 1207-1221.
 6. Olle JZ, John EC. *Developmental-Behavioral Pediatrics*: Elsevier Science Direct. 2019.
 7. ScienceDirect. Coping Strategies: an overview. 2019. Accessible at: <http://www.sciencedirect.com>.
 8. Ezeh OH. Contribution of Behavior Research to Public Health. Unpublished M P H Lecture Notes, A B U, Zaria Nigeria. 2010.
 9. Ezeh OH. Diagnosing Dysfunctional Coping in HIV-infected Persons *Open Journal of Medical Psychology*. 2019; 8.
 10. Dumont M, Provost MA. Resilience in adolescent's Protective role of social support, coping Strategies, self-esteem, and social activities on experience of stress and depression. *Journal of Youths and Adolescence*. 1999; 28: 343-363.