

Individual Factors of Social Acceptance in Patients Infected With Human Immunodeficiency Virus (HIV) at the Yazd Behavioral Consultation Center in Iran

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Abstract

Background: A considerable number of patients infected with HIV also have mental health problems. Individual psychotherapy is an effective way to treat these issues. Lack of social acceptance is a barrier to patients receiving proper medication and emotional/psychological support.

Objectives: The purpose of this study was to examine the individual factors of social acceptance in patients infected with human immunodeficiency virus.

Patients and Methods: Fifty HIV-infected patients who were registered in the Behavioral Consultation Center entered the study. Each of them filled out a questionnaire based on the Crown-Marlow social acceptance scale. Their answers were evaluated according to the questionnaire key.

Results: Forty-five patients (90%) were male and five (10%) were female. Their ages ranged between 28 and 52 years old. Other variables researched in this study include patients' age, sex, education, occupation, place of living, marital status, family history of HIV, and family history of psychological disorders. Employed patients experienced more social acceptance than housewives and people who were unemployed or retired.

Conclusions: This study showed that HIV-infected patients with jobs enjoy a great deal of acceptance from the people around them and a higher quality of life in general. It also led to suggestions for further study with the purpose of finding more effective solutions for HIV prevention and better strategies for dealing with psychological disorders. Such research could also help in providing an enhanced understanding of the potential psychological impact that AIDS has on patients in Iran.

Keywords: HIV, Social Support, Social Values, Social Distance

1. Background

Regardless of having symptoms or opportunistic infections, individuals who are HIV-positive and who have CD4 lymphocyte counts fewer than 350 cells/micro liters have been defined as patients with acquired immunodeficiency syndrome (AIDS). Biologically, HIV belongs to the retrovirus family and the Lenti virus subfamily (1).

The social risk of a health condition involves the possibility that a person will suffer socially if it is disclosed that he or she has a severe health problem (2). The psychosocial complications of declining health consist of psychological stress related to the poor quality of life that HIV-infected patients and their families suffer from, including the economic and psychosocial effects on family functioning that illness and death have (3). The major psychiatric problems in HIV-infected patients involve low

self-confidence issues; consequently, they are more prone than most people to suicide ideation and attempts (4). In recent years, studies indicate that a considerable number of patients infected with HIV also have mental health problems (3, 5).

Social acceptance of HIV disease involves help and support from the patient's social network (6) which is often associated with a better prognosis for the patient (7). This network includes family, friends, neighbors, and co-workers; an example of a lack of social acceptance is if any of these people do not accept the responsibility of giving medication and care to the patients (8).

In 1987, the first case of HIV/AIDS reported in Iran was a 6-year-old boy with hemophilia. An important factor that limits the extent of HIV in Iran is the social and cultural

beliefs and behaviors in that part of the world (9). Since there are many different potential factors involved in the social acceptance of HIV-infected patients in the psychotherapy process, we conducted a research to evaluate the social acceptance of patients in faceted with HIV who in 2012 received help from behavioral consultation centers in Yazd, a central province in Iran. To the best of our knowledge, the current study was one of the first research projects involving the assessment of the social acceptance of HIV-infected patients in Iran.

2. Objectives

The purpose of this study was to examine the individual factors of social acceptance in patients infected with human immunodeficiency virus and also seeks to evaluate the scores of social acceptance of the patients at the behavioral consultation center in the Yazd Province.

3. Patients and Methods

This was a cross-sectional study that was conducted in 2012 concerning behavioral disorders in HIV-infected patients at the consultation center in the city of Yazd, the capital of Yazd Province in Iran.

3.1. The Study Population

The patients chosen for the current study are the HIV-infected individuals who had records at the behavioral consultation center in Yazd.

3.2. Sampling Method

Out of the 70 patients needed, only 50 were willing to fill in the guide-scale social acceptance Crowne-Marlowe questionnaire, a Persian translation of the Crowne-Marlow questions that were used in the study. It comprised 33 yes-no questions (10). Subjects' responses were compared to a scale key in order to determine each individual's score. Scores of 0-8 represent the people who were most likely excluded from society yet who were not looking for answers to their lack of social acceptance. The score range 9-19 indicates that there was an average social acceptance of the patients' behavior, a result that is consistent with the social behavior in general. A score in between 20 and 33 demonstrates a high level of social acceptance, implying that the patients' actual behavior was very compatible with the rule sand norms of the society around them. The variables in this research include each patient's age, residential area, job, and gender.

3.3. Data analysis

The questionnaires were completed under the supervision of physicians and psychologists who were working at the Yazd behavioral consultation center. After the HIV patients completed the questionnaires, the physicians and psychologists evaluated there social acceptance scores of

the patients; these scores were calculated out of a total of 20. The specific data of patients were analyzed by statistical package for the social sciences (SPSS) version 14. In this study, t-test and chi-squared test were used and the P-values that are less than 0.05 are considered significant.

4. Results

The current study included 50 patients infected with HIV. The mean was 34.86 years old with arrange between 28 and 52 years old. Forty-five patients were male and five patients were female. Forty-five patients were living in urban areas with an average social acceptance score of 16.73, and five patients were rural inhabitants with an average score of 15. The difference between two groups, however, is not significant (P-Value = 0.403) (Table 1).

These results show that social acceptance scores are not correlated with patients' inhabitation status.

Twenty-six patients (52%) that were between 28 and 34 years old had a mean social acceptance score of 16.23. twenty-four patients (48%) between the ages of 35 and 52 had a mean social acceptance score of 16.91. The differences between these two groups are not significant either (P = 0.583). The results indicate that patients' social acceptance scores have no significant correlation with their age (Table 1). The mean social acceptance score of male patients' was 16.84 out of 20, and for females, it was 14 out of 20. These results reveal that there is no relationship between the social acceptance of AIDS patients and their gender (P = 0.168) (Table 1).

The next factor to consider in this study is the patients' level of education. For the two patients who were illiterate, their mean social acceptance score was 14.50. Eleven patients with a primary education had a mean score of 16.36. A total of 22 people who were educated up until secondary school had an average score of 16.63. Fifteen people had a higher education in the university and also diploma, with an average score of 16.56. None of the patients in the study had acquired post-diploma education. The data analysis indicates that the social acceptance of these patients is not associated with education level, since the difference among the patients with varying education levels is not statistically significant (P = 0.913).

In regard to the employment factor, seven patients who were laborers had a score of 17.42, while five patients who were housewives had a mean score of 14. Twenty-two patients were working in non-governmental organizations and had a score of 18.22, while the 16 unemployed and retired patients had a mean score of 14.68 (P = 0.036) (Table 1). Unlike in the studies of the other factors, these results are statistically significant. The Post-Hoc test showed significant differences between the social acceptance of patients working in non-governmental organizations and that of patients who are housewives (P = 0.043) or are unemployed or retired (P = 0.012), respectively.

Thus, the overall social acceptance of employed patients was more than that of unemployed or retired patients.

Table 1. The Social Acceptance Scores of Patients Infected With HIV in the Yazd Behavioral Consultation Center in 2012

Variables	Samples (N)	Average Score	P Value
Residential area			0.403
Urban	45	16.73 ± 4.46	
Rural	5	15 ± 2.91	
Total	50	16.56 ± 4.34	
Age			0.583
28 - 34	26	16.23 ± 5.16	
35 - 52	24	16.91 ± 3.32	
Total	50	16.56 ± 4.34	
Gender			0.168
Male	45	16.84 ± 4.43	
Female	5	14 ± 2.44	
Total	50	16.56 ± 4.34	
Job			0.036
Labor	7	17.42 ± 3.55	
Housewife	5	14 ± 2.44	
Non-governmental organizations	22	18.22 ± 4.17	
Unemployed - retired	16	14.68 ± 4.51	
Total	50	16.56 ± 4.34	

Moreover, in the current study, 17 patients were unmarried and had a mean score of 16.94. Thirty-one patients were married and had a score of 16.64. Two patients were divorced and had a score of 12. The low test scores of these people are most likely due to the low number of divorced individuals studied in this research; consequently, despite the outward appearance of these results, the social acceptance of these patients is actually not significantly associated with marital status ($P = 0.316$).

During the study, patients were also asked about their family history of HIV infection. For 46 patients who did not have any family history of HIV, the average score of social acceptance was 16.65. In the four people who did have a family history of HIV, the mean score was 15.50. However, the difference between having and not having a familial history of HIV is not statistically significant either ($P = 0.616$).

Thirty-five persons in the population did not have a family history of psychiatric disorders, achieving 16.57 as their average score of social acceptance. The 15 people who did have a family history of psychological disorders had an average score of 16.53. This test confirms that this difference is statistically significant ($P = 0.978$).

Concerning another factor in this research—the measurement of CD4 lymphocyte levels in patients—the person correlation coefficient which is a measure of the strength of the linear relationship between two variables showed no significant relationship between social acceptance and the rate of CD4 lymphocytes in patients ($r = 0.016$ and $P = 0.912$). Nevertheless, there was a significant correlation between the number of CD4 lymphocytes/micro liters and

the duration of the HIV affliction; as a result, the number of CD4 lymphocytes decreased during the infection.

5. Discussion

In the current study, social acceptance was recorded with scores of 15 and 16.73 in rural and urban areas, but the difference was not statistically significant (Table 1). In comparison, a study in Thailand discovered that the social acceptance of HIV-positive patients in rural areas was lower than that of patients in urban areas (11). In another study, urban women claimed that there were more obstacles to caring for HIV-positive patients in urban areas than in rural areas, possibly due to the high amount of HIV stigma existing in urban places (12).

In terms of the educational level of the patients, none of the patients had post-diploma education. The data analysis indicated that the social acceptance level of these patients is not associated with their education level, since the differences among the groups of patients with different education levels is not significant ($P = 0.913$). This fact may be due to the lack of post-graduate education in the patients involved in this study; otherwise, we would have expected a significant difference in the social acceptance of patients based on each one's level of education.

In regards to the measurement of CD4 lymphocyte levels, the analysis of data showed no significant relationship between social acceptance and the measurement of CD4 lymphocytes in patients ($r = 0.016$ and $P = 0.912$). This is similar to the findings of another research project that also revealed that patients' CD4 lymphocyte counts are not significantly associated with their quality of life (13).

Nevertheless, there was significant correlation between the numbers of CD4 lymphocytes/micro liters and the duration of the patients' HIV affliction; consequently, the number of CD4 in patients decreased during their period of infection, a result that seems to be an expected consequence of this phenomenon.

In our study, the factors involving patients' age, gender, level of education, family history of HIV infection and psychological disorders, time of HIV infection diagnosis, inhabitation, and marriage status did not have any significant correlation with the level of social acceptance they received (Table 1). Nevertheless, another study that was conducted in Kenya, Namibia, and Tanzania demonstrated that greater levels of depressive symptoms in HIV-positive patients were related to the factors of younger age and being female (14). These results may be consequences of low social support received by young people and female in those countries in general. However, another study indicated that gender was not a factor in determining any differences in identified psychiatric outcomes (6). Unfortunately, at the moment, there are no explanations for the conflicting results obtained from these additional studies. Further investigations need to be conducted in order to answer the question of why some factors have not achieved clear statistical significance in our research. That being said, it is also important to note that our study suffered from a major drawback: A very low number of patients participating in the study consequently, this disadvantage may very well have affected our findings and, in turn, the interpretation of the number of variables. Moreover, since the current study was one of the first to evaluate the different factors affecting social acceptance of HIV-positive patients in Iran, we faced a very limited availability of information at the time of this study, hindering our ability to accurately interpret the results we obtained. Needless to say, then, a great deal of work still remains to be done on researching this issue, which remains controversial.

In the current research, based on our data, significant differences were reported between social acceptance of patients working in non-governmental organizations and social acceptance of patients who were housewives ($P = 0.043$) or unemployed or retired ($P = 0.012$) (Table 1). Consequently, the findings of the present study suggest that the social acceptance of patients working in non-governmental organizations is more than that of unemployed and retired patients. These results are consistent with an earlier study in China, which was conducted on individuals with AIDS in order to document unemployment as a risk factor for suicidal ideation in these patients (7). Also, a study in Ethiopia confirmed the vital role employment play in improving AIDS patients' quality of life, and consequently, in increasing social acceptance of them as well (15). This evidence shows that having a job provides patients with not only as source of income, but also a social community, which in turn increases their opportunity to enjoy greater social ac-

ceptance. Various other sources of research on this topic also confirm that stigmatization of patients infected with HIV/AIDS is strongly related to the amount of fear of HIV and awareness about it that exist at the community level. Since people's attitudes are partly formed through social influence and social knowledge, relevant public-health interventions must be considered for reducing HIV/AIDS stigma in society. Thus, attention should be drawn to the role of social influences as HIV/AIDS stigma intervention (16). In addition, clinical interventions such as complementary therapies and behavioral-medicine interventions should be established for people living with HIV/AIDS, since these treatments have reportedly improved patients' quality of life (14).

Our study results did not include any score range of 20 - 33. This fact means that the actual behavior of the infected individuals was not ideally compatible with the cultural beliefs and community norms. At present, it appears that additional educational programs need to be established for people living with HIV/AIDS as a pathway toward achieving community norms. In comparison, results of a research project conducted in the United States indicate mild levels of depression and anxiety manifestations, as well as a moderate mean score of social acceptance, in the HIV-infected patients. The patients adapted to their difficult health condition by using positive reconstruction, coping methods, and social acceptance (17). The increasing trend to establish care and treatment services throughout the country will give more medical personnel the opportunity to provide holistic mental and psychosocial health care for people living with HIV.

5.1. Conclusion

This study showed that HIV-infected patients with jobs enjoy a great deal of acceptance from the people around them and a higher quality of life in general. It also led to suggestions for further study with the purpose of finding more effective solutions for HIV prevention and better strategies for dealing with psychological disorders. Such research could also help in providing an enhanced understanding of the potential psychological impact that AIDS has on patients in Iran. In order to help improve the attitude that members of society have towards HIV patients, sanitation authorities need to provide better policies and strategies for combating psychological disorders in the country.

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Footnotes

Authors' Contribution:All of the authors have the same contribution to this manuscript.

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